If continuation sheet 1 of 58

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **261 NORTH STREET BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) N 000 Initial Comments N 000 This plan constitutes our credible During the annual Licensure Survey conducted allegation of compliance. However, the on March 26-31, 2012, the facility was cited a submission of this allegation of Type "A" penalty for failure to ensure policies and compliance is not an admission that a procedures were in place to provide supervision deficiency exists or that one was cited to protect forty-two residents on the second floor correctly. This allegation of compliance from physical and mental abuse. The facility's is submitted to meet the requirements failure placed all the residents on the second floor established by state and federal law. in an environment which was detrimental to their This allegation of compliance is health, safety, and welfare. provided to reduce the scope and Severity of the F-tags cited as an Complaint investigation #29451 was completed Immediate Jeopardy during the annual Licensure Survey. No deficiencies were cited under Chapter 1200-8-6. Standards for Nursing Homes. N 400 1200-8-6-.04 Administration N 400 This Rule is not met as evidenced by: Based on interview the facility failed to apply for a waiver from the State to allow the facility's administrator to act as an administrator in the State of Virginia and State of Tennessee. A waiver request has been submitted The findings included: from the board for licensing healthcare Interview on March 26, 2012, at 2:00p.m., with the Administrator, in the Administrator's Office, revealed the facility was located in the State of facilities and the determination Tennessee and Virginia. Continued interview, at that time, confirmed the facility's Administrator of need will be made by the board. was the Administrator for both the Tennessee and the Virginia side of the facility. 4/16/12 N 401 1200-8-6-.04(1) Administration N 401 (1) The nursing home shall have a full-time (working at least 32 hours per week) Division of Health Care Facilities histoph A. Gaddy

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **261 NORTH STREET** BRISTOL NURSING HOME BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETE **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 401 Continued From page 1 N 401 administrator licensed in Tennessee, who shall not function as the director of nursing. Any change of administrators shall be reported in writing to the department within fifteen (15) days. The administrator shall designate in writing an individual to act in his/her absence in order to provide the nursing home with administrative direction at all times. The administrator shall assure the provision of appropriate fiscal On 3/30/2012 members of the resources and personnel required to meet the quality assurance committee, needs of the residents. Director of Nursing, Assistant Director of Nursing and or the Chief Executive, Corporate Director of clinical services reviewed the Staffing levels on 2nd Tennessee and decided to increase This Rule is not met as evidenced by: staffing by 43% (4- staff members Based on medical record review, observation, resulting in a 1C.N.A to 7 review of facility documentation, interview, and residents) on the 7A-7P shift and review of facility policy, the facility failed to be increased by 25% (2 staff members administered in a manner to ensure effective resulting in 1 C.N.A. to 8 residents systems were in place to identify and investigate) on the 7P -7A shift. Staffing will incidents of alleged abuse perpetrated by one be increased to six nursing resident (#21) with three residents (#17, #32, and assistants on the 7A-7P shift and #36); to formulate and implement a behavior care John of Complement April, 11, 2012 five nursing assistants on the 7P plan for two residents (#21 and #35) with 7A shift as soon as the facility can physically aggressive behaviors; and to provide maintain the new staffing level. adequate staff for supervision of aggressive This staffing will be permanent. behaviors for two residents (#21 and #35) with behavioral problems. The facility's failure placed all the residents on the 2nd Tennessee (2nd TN) unit in an environment which was detrimental to their health, safety, and welfare. The findings included: Interview with LPN #6, on March 30, 2012, at 9:25 a.m., and 10:00 a.m., at the 2nd TN nursing

Division of Health Care Facilities FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING ___ TN8201 03/31/2012 NAME OF PROVIDER OF SUPPLIES

NAME OF PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE	3/3 1/2012
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N 401	continued From page 2 station, confirmed resident #21 had a his aggressive behaviors. Continued intervicton firmed the resident was difficult to recontinued interview confirmed there were resident #21 needed to be on one to one supervision or every 15 minute checks, for safety of other residents, but the unit did always have available staff to monitor the more frequently than every 30 minutes.	ew direct. e times or the not	N 401	 Resident # 21 was placed on fifteen minute observation on 3/30/2012 at 10:30 am until he was transferred to another facility. Resident #21 was transferred to the Medical Center for an Evaluation and placement to a behavior unit on 3/30/2012 at 4:00pm. 	
	Interviews with the Social Services Direct the Senior Director of Clinical Services or 30, 2012, at 10:45 a.m., in the Assistant I of Nursing (ADON's) office, confirmed the was aware of resident #21's aggressive be and having hit other residents including re #35. Further interview confirmed every the minute monitoring had been provided, but resident was capable of hurting other resident was a thirty minute time frame. Interviews with the Senior Director of Clinic Services on March 30, 2012, at 12:20 p.m. conference room and with the DON on March 2012, at 9:30 a.m., in the ADON's office, confirmed the facility had no incident repoinvestigations or interventions related to the witnessed incidents regarding residents #2 #32, #35, and #36 and no incidents had be investigated as possible abuse. Further interviews confirmed they were unaware of incidents. Refer to 1200-8-604(15) (N-424) Administration.	n March Director e facility ehaviors esident hirty t the dents in cal h., in the earch 31, rts, he 21, #17, een f the		 The social worker completed a PHQ9 assessment Res. # 17 on 3/31/2012 to assess this resident for signs and symptoms of depression and to identify possible changes in signs and symptoms of mood distress since her last assessment. The assessment revealed that there was no change from the residents' baseline. (The PHQ-9 is a 9 item patient health questionnaire. A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder. The total severity provides a standard of communication with clinicians and mental health specialist.) 	
1	1200-8-604(15) Administration (15)Each nursing home shall adopt safety policies for the protection of residents from accident and injury.		N 424		
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	aggressive behavior confirmed the resident mediate resident #21 needers supervision or every safety of other resident more frequently that Interviews with the State Senior Director of 30, 2012, at 10:45 a. of Nursing (ADON's) was aware of resider and having hit other interviews with other interviews with the State Senior Director of 30, 2012, at 10:45 a. of Nursing (ADON's) was aware of resider and having hit other interviews with the state of the senior Director of State of	ocial Services Directo f Clinical Services on m., in the Assistant Di office, confirmed the t at #21's aggressive be esidents including res w confirmed every thir d been provided, but to of hurting other reside	r the sot resident March rector facility haviors ident ty		 The charge nurse completed assessments on res. # 17 on 3/1 3/22/2012 and 3/26/2012 all indinew skin issues. Resident # 17 care plan was developed by the interdisciplinateam (Administrator, Director of Nursing, Assistant Director of Musiness Office Manager, Dietal Manager, Activities Director, Services Director, Therapy Manon 11/17/2011. Interventions relabeliaviors that are listed are: doresident behavior and status as changes occur. Follow up with MPRN. The care plan was updated by services, MDS Coordinator and 	8/2012, icate no ary of Jursing, ry ocial agger) ated to cument	
	Interviews with the Se Services on March 30 conference room and 2012, at 9:30 a.m., in confirmed the facility hinvestigations or interviews dincidents re #32, #35, and #36 and investigated as possibinterviews confirmed thincidents. Refer to 1200-8-604(15) Admit (15)Each nursing home policies for the protectic accident and injury.	, 2012, at 12:20 p.m., with the DON on Marc the ADON's office, and no incident reports rentions related to the garding residents #21, no incidents had been abuse. Further ney were unaware of the 15) (N-424) Administration	in the ch 31, i, , #17, n	424	Quality Assurance Nurse and Sr Director of clinical services on 03/31/2012 to reflect the need to the MD and social services of chain mood and behaviors. • On 4/9/2012 the care plan and guide was updated to include: rethe resident with activity diversion when wandering such as folding when wandering at the sand hour gand or magazines.	notify anges care direct	

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **BRISTOL NURSING HOME 261 NORTH STREET** BRISTOL, TN 37625 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) N 401 Continued From page 2 N 401 The nurses note for Resident #32 station, confirmed resident #21 had a history of dated 1/13/2012 at 10:00 am states the aggressive behaviors. Continued interview resident is on antibiotics for a UTI. confirmed the resident was difficult to redirect. Resident gestures with c/o generalized Continued interview confirmed there were times discomfort, the MD gave a new order resident #21 needed to be on one to one for Lortab. The resident's son was supervision or every 15 minute checks, for the made aware as he was visiting at the safety of other residents, but the unit did not time. always have available staff to monitor the resident The nurses' note dated 1/14/2012 more frequently than every 30 minutes. states the resident "having questionable bleeding from rectal area. Interviews with the Social Services Director and MD notified with new orders to send the Senior Director of Clinical Services on March resident to ER for evaluation and 30, 2012, at 10:45 a.m., in the Assistant Director treatment. RP was notified of of Nursing (ADON's) office, confirmed the facility residents' status and aware of resident was aware of resident #21's aggressive behaviors going to the ER." Nurse's note dated and having hit other residents including resident 1/14/2012 at 6:00pm states the resident #35. Further interview confirmed every thirty was admitted to BRMC with a minute monitoring had been provided, but the diagnosis of Pneumonia. The hospital resident was capable of hurting other residents in was not notified of the alleged sexual a thirty minute time frame. assault. Interviews with the Senior Director of Clinical The Physician was notified by the Services on March 30, 2012, at 12:20 p.m., in the facility of the alleged sexual assault on conference room and with the DON on March 31, 4/10/2012 by the Chief Executive 2012, at 9:30 a.m., in the ADON's office, Officer, Director of Nursing, confirmed the facility had no incident reports, Corporate Quality Assurance Nurse, investigations or interventions related to the Sr. Director of Clinical Services.. witnessed incidents regarding residents #21, #17, #32, #35, and #36 and no incidents had been investigated as possible abuse. Further The social worker completed a interviews confirmed they were unaware of the PHQ9 assessment on resident # 32 on incidents. 3/31/2012 to assess for signs and symptoms of depression and to identify Refer to 1200-8-6-.04(15) (N-424) Administration possible changes in signs and symptoms of mood distress since her N 424 1200-8-6-.04(15) Administration last assessment. The assessment N 424 revealed that there was no change (15) Each nursing home shall adopt safety from the residents' baseline. (The policies for the protection of residents from PHQ-9 is a 9 item patient health accident and injury. questionnaire. A validated interview ion of Health Care Facilities that screens for symptoms of

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	station, confirmed reaggressive behavior confirmed the reside Continued interview resident #21 needed supervision or every safety of other reside always have available more frequently than	s. Continued intervient was difficult to red confirmed there were to be on one to one 15 minute checks, for ents, but the unit did re staff to monitor the every 30 minutes.	ew irect. e times or the not resident		depression. It provides a stan severity score and a rating fo of a depression. The total sev provides a standard of comm with clinicians and mental he specialist.)	r evidence erity unication	Completion Joh Hill 2
	Interviews with the So the Senior Director of 30, 2012, at 10:45 a.r of Nursing (ADON's) was aware of residen and having hit other re#35. Further interview minute monitoring had resident was capable a thirty minute time fra	f Clinical Services on m., in the Assistant D office, confirmed the t #21's aggressive be esidents including res v confirmed every thing been provided, but of hurting other resid	March irector facility haviors sident rty		 A skin assessment was compared the charge nurse on res. # 32 1/18/2012. The skin assessment revealed no bruising or redness where on the resident's body. Resident # 32 care plan was by social services, MDS Coord Quality Assurance Nurse and Street or of clinical services on 	on it ss any updated inator	
	Interviews with the Se Services on March 30, conference room and 2012, at 9:30 a.m., in to confirmed the facility hinvestigations or interviews dincidents reg #32, #35, and #36 and investigated as possible interviews confirmed the incidents. Refer to 1200-8-604(1)	, 2012, at 12:20 p.m., with the DON on Mar the ADON's office, ad no incident report entions related to the garding residents #2' no incidents had been abuse. Further ney were unaware of	in the ch 31, s, s, l, #17, en the		03/31/2012 to reflect the need to the MD and social services of c in mood and behaviors.	o notify hanges	
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	(15)Each nursing home policies for the protectic accident and injury	shall adopt safety					

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	In Scotland In In Scotland In Scotland In In Scotland In	Continued From pages station, confirmed resaggressive behaviors confirmed the resider Continued interview of resident #21 needed supervision or every safety of other resider always have available more frequently than earlier to supervision or every safety of other resider always have available more frequently than earlier to supervision or every safety of other resident of Nursing (ADON's) of Nursing have sident was capable of thirty minute time from the reviews with the Sent ervices on March 30, and the Nursing the facility have stigations or intervesting the stigated as possible the reviews confirmed the stigated as possible the	sident #21 had a hist c. Continued intervient was difficult to redict confirmed there were to be on one to one 15 minute checks, for the staff to monitor the revery 30 minutes. cial Services Director Clinical Services on In., in the Assistant Director Clinical Services on In., in the Assistant Director of Clinical Services on In., in the Assistant Director of Clinical Services on In., in the Assistant Director of Clinical Services on In., in the Assistant Director of Clinical Services on In., in the Assistant Director of Clinical Services on In., in the Assistant Director of Clinical Services on In., in the Assistant Director of Clinical Services on In., in the Assistant Director of Clinical Services of Clinical	rect. times r the ot resident r and March rector racility haviors ident by he ents in #17, n	N 401	• The care plan was updated for resident # 35 by social services, Quantum Assurance Nurse and Sr. Director clinical services on 03/31/2012 to the need to notify the MD and soc services of changes in mood and behaviors. • The care plan for resident # 35 updated on 4/2/2012 with the follo interventions: place the resident of to one observation when he display aggressive behaviors toward other residents and, notify the MD and services when the resident displays aggressive behaviors toward other residents. The charge nurse, unit manager and or Nursing supervisor may place the resident on one to on observation for aggressive behavior. • Resident # 35 was seen by Psychiatric Services on 3/27/2012 related to recent aggressive behavior The following Recommendations we made by Psych. Services during the last visit. Increase Exelon Patch to mg/24 hrs, topically for maximum cognitive benefit. Increase Seroque XR 400 mg at 5 pm daily for agitati and combative behavior.	MDS ality r of reflect cial was owing n one ys social s or ne rs.	sylvten poter	
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BRISTOL NURSING HOME 261 NORTH STREET	/31/2012
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station, confirmed resident #21 had a history of aggressive behaviors. Continued interview confirmed the resident was difficult to redirect. Continued interview confirmed there were times resident #21 needed to be on one to one supervision or every 15 minute checks, for the safety of other residents, but the unit did not always have available staff to monitor the resident more frequently than every 30 minutes. Interviews with the Social Services Director and the Senior Director of Clinical Services on March 30, 2012, at 10:45 a.m., in the Assistant Director of Nursing (ADONs) office, confirmed the facility was aware of resident #21's aggressive behaviors and having hit other residents in a thirty minute monitoring had been provided, but the resident was capable of hurting other residents in a thirty minute time frame. Interviews with the Senior Director of Clinical Services on March 30, 2012, at 22:20 p.m., in the conference room and with the DON on March 31, 2012, at 9:30 a.m., in the ADON's office, confirmed the facility had no incident reports, investigations or interventions related to the witnessed incidents regarding residents #21, #17, #32, #35, and #36 and no incidents had been investigated as possible abuse. Further interviews confirmed they were unaware of the incidents. N 424 1200-8-604(15) Administration (15)Each nursing home shall adopt safety policies for the protection of residents from accident and injury.	Complete Value 4/1/12

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 261 NORTH STREET **BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) N 401 Continued From page 2 N 401 Resident # 36 care plan was updated station, confirmed resident #21 had a history of by social services, MDS Coordinator, aggressive behaviors. Continued interview Social worker, Quality Assurance confirmed the resident was difficult to redirect. Nurse and Sr. Director of clinical Continued interview confirmed there were times services on 03/31/2012 with resident #21 needed to be on one to one interventions to refer to Psych services supervision or every 15 minute checks, for the and monitor every thirty minutes until safety of other residents, but the unit did not evaluated by psych. Services. always have available staff to monitor the resident The MD was notified and agreed more frequently than every 30 minutes. with recommendations from Interviews with the Social Services Director and the Senior Director of Clinical Services on March Duk Puk 4/11/2 30, 2012, at 10:45 a.m., in the Assistant Director of Nursing (ADON's) office, confirmed the facility was aware of resident #21's aggressive behaviors and having hit other residents including resident #35. Further interview confirmed every thirty minute monitoring had been provided, but the psychiatric services for Medication resident was capable of hurting other residents in changes and the discontinuation of the a thirty minute time frame. frequent checks on 4/3/2012. Care plan was updated with D/C Interviews with the Senior Director of Clinical frequent checks on 4/3/2012. Services on March 30, 2012, at 12:20 p.m., in the Skin assessment completed by the conference room and with the DON on March 31, charge nurse on resident #36 on 2012, at 9:30 a.m., in the ADON's office, 3/18/2012, 3/30/2012 revealed no confirmed the facility had no incident reports, bruising or redness. investigations or interventions related to the witnessed incidents regarding residents #21, #17. #32, #35, and #36 and no incidents had been investigated as possible abuse. Further interviews confirmed they were unaware of the incidents. Refer to 1200-8-6-.04(15) (N-424) Administration N 424 1200-8-6-.04(15) Administration N 424 (15) Each nursing home shall adopt safety policies for the protection of residents from accident and injury.

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	interviews confirmed the incidents. Refer to 1200-8-604(1	ey were unaware of to the street (N-424) Administr			the facility's Chief Executive (with establishing a sign on bon referral bonus plan and a perf attendance bonus plan for the staff.	us plan, ect		
	1200-8-604(15) Admir (15) Each nursing home policies for the protectic accident and injury.	shall adopt safety	N	424				

Division of Health Care Facilities FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **261 NORTH STREET BRISTOL NURSING HOME** BRISTOL, TN 37625 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) N 401 Continued From page 2 N 401 station, confirmed resident #21 had a history of The RN supervisor completed an aggressive behaviors. Continued interview audit on all blood sugar flow sheets to confirmed the resident was difficult to redirect. assess for compliance with M.D. Continued interview confirmed there were times notification related to resident #21 needed to be on one to one hypo/hyperglycemic on 4/10/2012. supervision or every 15 minute checks, for the safety of other residents, but the unit did not The DON, ADON and Social always have available staff to monitor the resident Services reviewed psychiatric more frequently than every 30 minutes. services progress notes for visit from 3/30/2012 to 4/3/2012 to Interviews with the Social Services Director and the Senior Director of Clinical Services on March 30, 2012, at 10:45 a.m., in the Assistant Director of Nursing (ADON's) office, confirmed the facility was aware of resident #21's aggressive behaviors and having hit other residents including resident #35. Further interview confirmed every thirty ensure psychiatric recommendations were completed minute monitoring had been provided, but the timely. All recommendations were resident was capable of hurting other residents in place in the physician notification a thirty minute time frame. folder for the physician to review. MD and or NP make facility visits Interviews with the Senior Director of Clinical Services on March 30, 2012, at 12:20 p.m., in the four times a week to assess the conference room and with the DON on March 31, residents and to review consultant 2012, at 9:30 a.m., in the ADON's office, recommendations that have been confirmed the facility had no incident reports, placed in the physician folder. investigations or interventions related to the Skin assessment was completed on witnessed incidents regarding residents #21, #17, 100% of the resident in 2nd #32, #35, and #36 and no incidents had been Tennessee by the charge nurse to investigated as possible abuse. Further assess for unknown bruises and or interviews confirmed they were unaware of the abrasions. incidents. Refer to 1200-8-6-.04(15) (N-424) Administration N 424 1200-8-6-.04(15) Administration N 424

accident and injury.

(15) Each nursing home shall adopt safety policies for the protection of residents from

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 261 NORTH STREET **BRISTOL NURSING HOME** BRISTOL, TN 37625 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 401 Continued From page 2 N 401 The PHQ9 assessment tool was used station, confirmed resident #21 had a history of to assess residents for signs and aggressive behaviors. Continued interview symptoms of depression and to confirmed the resident was difficult to redirect. identify possible changes in signs Continued interview confirmed there were times and symptoms of mood distress resident #21 needed to be on one to one since his/her last assessment. supervision or every 15 minute checks, for the (The PHO-9 is a 9 item patient safety of other residents, but the unit did not health questionnaire. A validated always have available staff to monitor the resident interview that screens for symptoms more frequently than every 30 minutes. of depression. It provides a standardized severity score and a Interviews with the Social Services Director and rating for evidence of a depressive the Senior Director of Clinical Services on March disorder. The total severity 30, 2012, at 10:45 a.m., in the Assistant Director provides a standard of of Nursing (ADON's) office, confirmed the facility Communication with clinicians and was aware of resident #21's aggressive behaviors mental health specialist.) and having hit other residents including resident #35. Further interview confirmed every thirty minute monitoring had been provided, but the resident was capable of hurting other residents in a thirty minute time frame. Interviews with the Senior Director of Clinical Services on March 30, 2012, at 12:20 p.m., in the conference room and with the DON on March 31, 2012, at 9:30 a.m., in the ADON's office, confirmed the facility had no incident reports, investigations or interventions related to the witnessed incidents regarding residents #21, #17, #32, #35, and #36 and no incidents had been On 3/30/2012 members of the quality investigated as possible abuse. Further assurance committee, Director of interviews confirmed they were unaware of the Nursing, Assistant Director of incidents. Nursing and the Chief Executive Officer, Corporate Director of Refer to 1200-8-6-.04(15) (N-424) Administration clinical services reviewed the Staffing levels on 2nd Tennessee and N 424 1200-8-6-.04(15) Administration decided to increase staffing by 43% N 424 (4- staff members resulting in a ratio (15) Each nursing home shall adopt safety of 1 c.n.a. to 7 residents) on the 7Apolicies for the protection of residents from 7P shift and increased by 25% (2 accident and injury.

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 261 NORTH STREET BRISTOL NURSING HOME BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 401 Continued From page 2 N 401 station, confirmed resident #21 had a history of staff members resulting in 1 c.n.a. to aggressive behaviors. Continued interview 8 residents) on the 7P -7A shift. confirmed the resident was difficult to redirect. Staffing will be increased to six Continued interview confirmed there were times nursing assistants on the 7A-7P shift resident #21 needed to be on one to one and five nursing assistants on the 7P supervision or every 15 minute checks, for the - 7A shift as soon as the facility can safety of other residents, but the unit did not maintain the new staffing levels. This always have available staff to monitor the resident will be permanent staffing. more frequently than every 30 minutes. Interviews with the Social Services Director and · To increase and retain the increased the Senior Director of Clinical Services on March number of staff on 2nd Tennessee the 30, 2012, at 10:45 a.m., in the Assistant Director facility has implemented the following: of Nursing (ADON's) office, confirmed the facility · Placed a newspaper ad locally, on was aware of resident #21's aggressive behaviors line advertisement for C.N.A'.s, LPN'.s and having hit other residents including resident and RN's. #35. Further interview confirmed every thirty · Offering a \$500.00 new hire sign on minute monitoring had been provided, but the Bonus for LPN's and C.N.A.'s. resident was capable of hurting other residents in • Offering a \$250.00 referral Bonus to a thirty minute time frame. current employee that refers other Congelition Date 1/11/2 nursing staff that are hired and stay Interviews with the Senior Director of Clinical past ninety days. Services on March 30, 2012, at 12:20 p.m., in the · A perfect attendance Bonus of an conference room and with the DON on March 31, additional twenty-five cent per hour 2012, at 9:30 a.m., in the ADON's office, worked per pay period has been confirmed the facility had no incident reports, implemented for nursing assistants. investigations or interventions related to the witnessed incidents regarding residents #21, #17, All staff will receive education on #32, #35, and #36 and no incidents had been managing residents with Dementia and investigated as possible abuse. Further dementia related behaviors. Corporate interviews confirmed they were unaware of the Hospice provider provided the above incidents. training by April 11, 2012. The training also included a review of the Refer to 1200-8-6-.04(15) (N-424) Administration facility policy on Behavior assessment and monitoring by the Assistant N 424 1200-8-6-.04(15) Administration N 424 Director of Nursing. (15) Each nursing home shall adopt safety policies for the protection of residents from accident and injury.

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **261 NORTH STREET BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 401 Continued From page 2 N 401 station, confirmed resident #21 had a history of All nursing staff will receive aggressive behaviors. Continued interview education on the types of abuse, the confirmed the resident was difficult to redirect. policy and procedure for reporting and Continued interview confirmed there were times investigating all incidents of abuse. resident #21 needed to be on one to one Sexual behaviors and possible sexual supervision or every 15 minute checks, for the abuse by the Senior Director of safety of other residents, but the unit did not Clinical Services with Health Services always have available staff to monitor the resident management group, the Quality more frequently than every 30 minutes. Assurance Nurse and or the Director of Nursing by April 10th, 2012. This Interviews with the Social Services Director and training also included mandatory the Senior Director of Clinical Services on March reporting of Elder Abuse Act 30, 2012, at 10:45 a.m., in the Assistant Director of Nursing (ADON's) office, confirmed the facility was aware of resident #21's aggressive behaviors · The Director of Nursing, Assistant and having hit other residents including resident Director of Nursing and the Chief #35. Further interview confirmed every thirty Executive officer (Administrator) will minute monitoring had been provided, but the resident was capable of hurting other residents in a thirty minute time frame. investigate all allegations of abuse as soon as they are notified of the Interviews with the Senior Director of Clinical allegation and will report the Services on March 30, 2012, at 12:20 p.m., in the allegations and the findings of the conference room and with the DON on March 31, investigation to the appropriate state 2012, at 9:30 a.m., in the ADON's office. agencies. confirmed the facility had no incident reports. Deste 4/11/12 investigations or interventions related to the The interdisciplinary team will witnessed incidents regarding residents #21, #17, review all allegations of abuse in the #32, #35, and #36 and no incidents had been daily clinical meeting and in the investigated as possible abuse. Further monthly Quality Assurance meeting. interviews confirmed they were unaware of the incidents. • The Director of Nursing; Assistant Director of Nursing; Staff Refer to 1200-8-6-.04(15) (N-424) Administration Development Coordinator and or the Quality Assurance Nurse will provide N 424 1200-8-6-.04(15) Administration N 424 re-education to all licensed nurses regarding Physician notification of (15)Each nursing home shall adopt safety hyperglycemic blood sugar results by April 11th, 2012. policies for the protection of residents from accident and injury.

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **261 NORTH STREET** BRISTOL NURSING HOME BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 401 Continued From page 2 N 401 · The Director of Nursing; Assistant station, confirmed resident #21 had a history of Director of Nursing; Staff aggressive behaviors. Continued interview Development Coordinator and or the confirmed the resident was difficult to redirect Quality Assurance Nurse will provide Continued interview confirmed there were times re-education to all licensed nurses resident #21 needed to be on one to one regarding timely notification of supervision or every 15 minute checks, for the Psychiatric recommendations to the safety of other residents, but the unit did not attending Physicians. always have available staff to monitor the resident more frequently than every 30 minutes. • The Unit Managers will audit the diabetic flow records daily beginning Interviews with the Social Services Director and April 1, 2012 to ensure Physician the Senior Director of Clinical Services on March notification of hyperglycemic episodes 30, 2012, at 10:45 a.m., in the Assistant Director is documented on the Blood sugar flow of Nursing (ADON's) office, confirmed the facility sheets. The weekend Nurse Manager was aware of resident #21's aggressive behaviors will complete the daily audits on and having hit other residents including resident Saturday and Sunday. Daily audits will #35. Further interview confirmed every thirty be completed daily four weeks then. minute monitoring had been provided, but the Three times a week for four weeks and resident was capable of hurting other residents in then, weekly for four weeks and then a thirty minute time frame. PRN. Interviews with the Senior Director of Clinical · The Unit managers will report audit Services on March 30, 2012, at 12:20 p.m., in the findings to the interdisciplinary team Conglisher ach conference room and with the DON on March 31. in the daily clinical meeting. The 2012, at 9:30 a.m., in the ADON's office. DON/ADON will maintain all Audit confirmed the facility had no incident reports, tools in the survey readiness binder in investigations or interventions related to the the DON's office. witnessed incidents regarding residents #21, #17. #32, #35, and #36 and no incidents had been The DON/ ADON and or Quality investigated as possible abuse. Further Assurance Nurse will audit 100% of interviews confirmed they were unaware of the the diabetic flow sheets weekly to incidents. ensure Physician notification of hyperglycemic episodes has been Refer to 1200-8-6-.04(15) (N-424) Administration N 424 1200-8-6-.04(15) Administration N 424 (15) Each nursing home shall adopt safety policies for the protection of residents from accident and injury.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 261 NORTH STREET **BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 401 Continued From page 2 N 401 documented on the blood sugar flow station, confirmed resident #21 had a history of aggressive behaviors. Continued interview sheets. Audits will be completed weekly confirmed the resident was difficult to redirect. for eight weeks and then PRN. Continued interview confirmed there were times · The DON and or ADON will review resident #21 needed to be on one to one supervision or every 15 minute checks, for the Psychiatric consultation notes after safety of other residents, but the unit did not each visit to ensure recommendations for medication adjustments are called always have available staff to monitor the resident Complete Data 9/11/12 more frequently than every 30 minutes. to the Physician in a timely manner. Interviews with the Social Services Director and • The DON/ ADON and or Quality the Senior Director of Clinical Services on March Assurance Nurse will audit 100% of 30, 2012, at 10:45 a.m., in the Assistant Director the Psychiatric notes and the medical of Nursing (ADON's) office, confirmed the facility record to ensure the physician is was aware of resident #21's aggressive behaviors notified of recommendations for and having hit other residents including resident medication changes from Psychiatric #35. Further interview confirmed every thirty services. Audits will be completed minute monitoring had been provided, but the weekly for eight weeks and then resident was capable of hurting other residents in biweekly for eight weeks and then a thirty minute time frame. PRN. Interviews with the Senior Director of Clinical · The DON/ADON will report audit Services on March 30, 2012, at 12:20 p.m., in the findings to the interdisciplinary team conference room and with the DON on March 31. in the monthly Quality Assurance 2012, at 9:30 a.m., in the ADON's office. Committee meeting until system confirmed the facility had no incident reports. compliance is achieved. investigations or interventions related to the witnessed incidents regarding residents #21, #17. #32, #35, and #36 and no incidents had been investigated as possible abuse. Further interviews confirmed they were unaware of the incidents. Refer to 1200-8-6-.04(15) (N-424) Administration N 424 1200-8-6-.04(15) Administration N 424 (15) Each nursing home shall adopt safety policies for the protection of residents from accident and injury.

Division of Health Care Facilities

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **261 NORTH STREET BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) N 401 Continued From page 2 N 401 The MDS Coordinators were restation, confirmed resident #21 had a history of educated on OBRA required MDS aggressive behaviors. Continued interview assessments and facility required confirmed the resident was difficult to redirect. quarterly assessments, care plan Continued interview confirmed there were times development and implementation by resident #21 needed to be on one to one the Quality assurance Nurse on supervision or every 15 minute checks, for the 4/5/2012. safety of other residents, but the unit did not The interdisciplinary team will always have available staff to monitor the resident receive education on OBRA required more frequently than every 30 minutes. MDS assessments and facility required quarterly assessments, care plan Interviews with the Social Services Director and development and implementation by the Senior Director of Clinical Services on March the Quality assurance Nurse by 30, 2012, at 10:45 a.m., in the Assistant Director Date
4/11/12 4/10/2012. of Nursing (ADON's) office, confirmed the facility All licensed nurses will receive was aware of resident #21's aggressive behaviors education on developing Interim care and having hit other residents including resident #35. Further interview confirmed every thirty plans for new admissions by 4/11/2012. The Quality Assurance Nurse, Director minute monitoring had been provided, but the resident was capable of hurting other residents in of Nursing, Assistant Director of Nursing and or the staff development a thirty minute time frame. Coordinator will provide the Interviews with the Senior Director of Clinical education. The clinical team will review medical Services on March 30, 2012, at 12:20 p.m., in the conference room and with the DON on March 31, records of new admissions in the daily 2012, at 9:30 a.m., in the ADON's office. clinical meeting to ensure an interim confirmed the facility had no incident reports. care plan is implemented within investigations or interventions related to the witnessed incidents regarding residents #21, #17. #32, #35, and #36 and no incidents had been investigated as possible abuse. Further interviews confirmed they were unaware of the twenty-four hours of admission to the incidents. facility. Refer to 1200-8-6-.04(15) (N-424) Administration N 424 1200-8-6-.04(15) Administration N 424 (15) Each nursing home shall adopt safety policies for the protection of residents from accident and injury.

FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 261 NORTH STREET **BRISTOL NURSING HOME** BRISTOL, TN 37625 (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) N 424 N 424 Continued From page 3 This Rule is not met as evidenced by: The facility will ensure that the Based on medical record review, observation, residents' environment is as free of interview, and review of facility documentation, the facility failed to provide supervision for accidents hazards as is possible; and aggressive behaviors for two residents (#21 and each resident receives adequate supervision and assistance devices to #35) with behavioral problems; failed to ensure prevent accidents. safe bed rails for one resident (#8); and failed to ensure supervision for wandering for one resident (#17) of thirty-nine residents reviewed. 1. What corrective actions(s) will be accomplished for those residents found The facility's failure to supervise resident #21 and resident #35 with aggressive and abusive to have been affected by the alleged behaviors placed the residents on the 2nd deficient practice? Tennessee (2nd TN) unit in an environment which was detrimental to their health, safety, and welfare. • On March 27, 2012 the full side rails The findings included: were immediately removed from Resident #8 bed. The resident was Resident #21 was admitted to the facility on placed in a Geri-chair. The residents' Completion July 4/11/12 August 19, 2011, with diagnoses including Mental old bed was replaced with a new bed Disorder, Anxiety, and Previous Head Injury with assist rails within one hour. Traumatic. · A side rail assessment and the care plan were updated on 4/9/2012 for Medical record review of an assessment dated resident #8 by the unit manager. The February 12, 2012, revealed the resident scored unit manager notified the staff of the 4 out of 15 on the Brief Interview for Mental updated care plan immediately. Status, indicating severe cognitive impairment, had physical behavioral symptoms directed toward others, and was independent with ambulation. Medical record review of the Care Plan last

reviewed February 16, 2012, revealed the only behavior and cognitive problems the facility had identified and implemented interventions for were related to "...impaired thought processes, short

URYC11

PRINTED: 04/10/2012

FORM APPROVED Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING TN8201 03/31/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **261 NORTH STREET** BRISTOL NURSING HOME BRISTOL, TN 37625 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) N 424 | Continued From page 4 N 424 • The care plan for res. # 17 was and long term memory loss associated with updated by social services, MDS dementia...Potential for social isolation related to Coordinator and Quality Assurance facility admission and cognitive Nurse and Sr. Director of clinical impairment...Experiences periods of high anxiety services on 03/31/2012 to reflect the AEB (as exemplified by) cursing, pacing, and need to notify the MD and social combative behavior toward staff/ex wife related to services of changes in mood and dementia, newly admitted..." Review of the care behaviors. plan revealed interventions included. " On 4/11/2012 the care plan for res. # ...Approach resident warmly and positively...Allow 17 was updated to include: redirect the resident opportunity to make choices and resident with activity diversion when participate in cares. Reinforce with resident wandering such as folding wash cloths, unacceptability of resident's verbal abuse. Do not looking at the sand hour glass and argue with resident. Remove resident from public magazines. area when behavior is disruptive. Talk with • The Director of Nursing updated the resident in calm voice when behavior is care guide for resident #17 on disruptive. Social Services to evaluate resident 4/11/2012 with the diversional activities and visit with resident prn (as needed). Monitor such as folding wash cloths, looking at and document resident behavior. Report the sand hour glass and magazines. increase in negative behavior to physician ..." The charge nurses will utilize the Medical record review of the Nurse's Notes dated Psychoactive Medication monthly flow December 4, 2011, at 8:30 p.m., revealed, "Res record to document resident changes in (resident) had altercation (with) another res. Res mood and or behaviors. It is the caught rummaging in res room. Both separated. responsibility of the charge nurses to Res redirected..." notify the MD and social services of Completion Date 4/11/11 any mood and behavior changes. Medical record review of the Mental/Behavioral The charge nurse will notify the MD Health Progress Notes dated January 3, 2012, and social services of residents revealed, "...frustrated/angry...delusional exhibiting abusive behaviors beliefs...replied that he was concerned about his immediately. ex-wife...went on to say that he has seen his wife w/ (with) other residents and this bothered him...went on to reiterate further delusional beliefs about his ex-wife's behaviors...tends to obsess about this ... "

Medical record review of the Nurse's Notes dated

January 12, 2012, at 6:30 p.m., revealed, "...Resident wandering (up and down) hallway pushing residents in rooms pushing chairs

URYC11

FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **261 NORTH STREET BRISTOL NURSING HOME** BRISTOL, TN 37625 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 424 Continued From page 5 N 424 around hallways - at nsg (nursing) station The social worker completed a frequent (with) request re: (regarding) room stay. PHQ9 assessment on 3/31/2012 to Resident also displaying some protectiveness i.e. assess resident #17 for signs and (that is) female residents - resident raised his symptoms of depression and to identify voice in loud tone this am (morning) when talking possible changes in signs and to male resident. This resident thought other symptoms of mood distress since her male resident was (after) his wife. Residents last assessment. The assessment separated - explained to this resident (reoriented) revealed that there was no change minimal success noted..." from the residents' baseline. • (The PHQ-9 is a 9 item patient Medical record review revealed no new health questionnaire. A validated interventions were implemented for increased interview that screens for symptoms of supervision of resident #21. depression. It provides a standardized severity score and a rating for evidence Interview with Certified Nurse Aide (CNA) #1 on of a depressive disorder. The total March 30, 2012, at 1:52 p.m., in the conference severity provides a standard of room, confirmed resident #21 had aggressive communication with clinicians and behaviors towards other male residents and had mental health specialist.) been known to strike residents. Continued interview confirmed the resident frequently wandered the halls of the units, in other resident rooms, and liked to be with female residents in their rooms. Continued interview confirmed the · The charge completed a Skin CNA had worked on two occasions in January assessments on resident #17 on 2012, when the resident was seen exiting a 3/18/2012, 3/22/2012 and 3/26/2012 all female resident's room. Continued interview Pate Pate 4/11/12 indicate no new skin issues. confirmed the first instance the CNA recalled was around the week of January 9, 2012, the resident was seen exiting a room (empty resident room • Resident # 21 was placed on fifteen which had not been assigned to any residents) minute observation on 3/30/2012 at carrying linen. Interview confirmed the CNA 10:30 am. entered the room and resident #32 was in bed with no clothes on, and a brief had been removed · Resident #21 was transferred to the and was laying on the bed with blood present in

the brief. Continued interview confirmed the CNA

reported the incident to LPN #11. Continued

interview confirmed the CNA also observed the

resident (resident #21) exiting female resident #17's room sometime in January, and upon entering the room, found the resident fully

Medical Center for an Evaluation and

3/30/2012 at 4:00pm. This resident

will not be readmitted to the facility.

placement to a behavior unit on

FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 261 NORTH STREET **BRISTOL NURSING HOME** BRISTOL, TN 37625 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) N 424 Continued From page 6 N 424 clothed, one side of the brief undone, and pants on the resident. Continued interview confirmed · The social worker completed a staff "just redirected" the resident when he was PHO9 assessment on 3/31/2012 to noted on the female hall. assess resident # 6 and res. # 35 for signs and symptom of depression and Interview with Licensed Practical Nurse (LPN) to identify possible changes in signs #11 on March 31, 2012, at 7:15 a.m., and 9:00 and symptoms of mood distress since a.m., on 2nd Tennessee, confirmed the resident his last assessment. The assessments #21 was a "handful" and nursing were "constantly revealed that there was no change trying to keep track of where he might be...takes from the residents 'baseline clothes." Continued interview confirmed the LPN • (The PHO-9 is a 9 item patient was working sometime in January when CNA #1 health questionnaire. A validated reported to LPN #11 resident #21 had exited a interview that screens for symptoms of room (empty resident room which had not been depression. It provides a standardized assigned to any residents) carrying ladies severity score and a rating for evidence clothing. Continued interview confirmed resident of a depressive disorder. The total #32 was in the room with no clothes on, and a severity provides a standard of brief had been removed (unknown who removed) communication with clinicians and with blood in the brief and blood on the resident's mental health specialist.) rectal area. Continued interview confirmed LPN #11 was not the nurse assigned to care for Coupletion Desti 4/11/12 resident #32 but cleaned the resident and reported it to the resident's nurse. Continued The charge nurse completed a Skin interview confirmed the resident was sent to the assessments on resident #6 on hospital the same day. Continued interview 3/18/2012; 3/22/2012 and confirmed the LPN did not remember what date it 3/26/2012. There was no indication of was, but the resident was sent to the hospital and bruising or redness anywhere on the the occurrence was around 11:00 a.m., to 12:00 resident body. p.m. Continued interview confirmed the LPN had never known resident #32 to completely undress herself. Continued interview confirmed the staff The care plan was updated for res. # had difficulty keeping up with resident #21 with all 6 by social services, MDS Coordinator, the nursing duties to care for other residents. Social Worker and Quality Assurance Continued interview confirmed resident #21 was Nurse and Sr. Director of clinical aggressive and attempting to redirect the resident services on 03/31/2012 to reflect the was difficult especially on the female hall, where need to notify the MD and social the resident liked to wander. Continued interview

confirmed the LPN was aware of one incident in the dayroom in which resident #21 struck another male resident who was attempting to give a doll

FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING TN8201 03/31/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 261 NORTH STREET **BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 424 N 424 Continued From page 7 services of changes in mood and to a female resident (witnessed by staff as they behaviors. were walking by the dayroom) and one incident where another male resident (no longer residing • The Corporate Quality Assurance Nurse and the Sr. Director of clinical in the facility) reported resident #21 had entered services immediately notified the the resident's room and struck him. charge nurses on duty of the changes made to the care plan. Changes in Medical record review of the nursing notes for resident care are then discussed during January 2012, for resident #32 revealed no documentation of an incident with resident #21 nursing shift change. exiting the room. Review of the nursing notes for The Director of Nursing updated January 14, 2012, at 10:50 a.m., revealed, "Res resident care guides to ensure the 1 (resident) (resident #32) having questionable nursing assistants were aware of the bleeding from rectal area. MD (physician) notified care plan changes on 4/11/2012 for res. ...Send res to ER (emergency room)..." Medical record review of the Psychiatric Notes for resident #21 dated January 17, 2012, revealed, "...staff report that resident continues to have a • The care plan for res. # 35 was preoccupation with female residents. He has updated on 4/2/2012 with a new been found in a female resident's bed in the past. intervention to Place the resident on He is always pushing their with C's (wheelchairs) one on one observation and notify the or holding hands with various other residents. M.D. and social services when the Staff are concerned this could escalate into a resident becomes aggressive with other problem and wonder if depo-provera might be a residents. Charge nurses will place possibility...he (resident #21) denies the above resident's on one to one observation behaviors..." and notify the MD and social services when any resident displays aggression Medical record review of the Nurse's Notes dated of any type toward another resident. January 18, 2012, at 3:45 p.m., revealed, "...CNA The charge nurse and or nursing (Certified Nurse Aide) came to this nurse and supervisor will assign a staff member reported finding (resident #21) in (room number) to monitor a resident needing one on with him exiting the doorway, female residents one observation. One on one

brief undone & (and) her positioning vest off her

body. CNA directed male resident back up

hallway & redressed female resident..." 4:30

p.m., "Nurse practitioner psych (psychiatric)

month for sexual behaviors..."

ordered Depo Provera (hormonal medication to treat sexual behaviors) IM (intramuscular) once a

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observations are documented on a

The observations are filed in the

nurses note or an observations form.

medical record at the end of each shift.

Division of Health Care Facilities

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBER:	A. BUILDII	(AAA-)	(X3) DATE COMP	
		TN8201		B. WING		03/	31/2012
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
BRISTO	L NURSING HOME			TH STREET , TN 37625			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
	Medical record revieinterventions were insupervision of resident Medical record revieinal January 19, 2012, a walking down hallway (Tennessee) looking white sock in doorja entering room, (resident was be disturbed by incident was be disturbed by incident was some control of the control of t	ew revealed no new implemented for increment #21. ew of the Nurse's Not to 6:15 p.m., revealed ay on long hall 2nd Till grow (resident #21) may for (resident #21) was in bed male resident (resident #21) was in bed male resident (resident #21) to rise out of bed at the ere off, underwear or earts on & exit room a semale resident (resident #21) was of to his location through we revealed no new implemented for increment #21. ew of the Mental/Behaves for resident #21 devealed, "(Nursing so is to visit w/ patient du (patient) entering others in the was aware of resident entering others.	tes dated , "While N oticed a on A of ent #35). eming to cottom of n. He and was ent #35) ot. checked ghout pm ased avioral ated staff te to ner a er Pt of times ding a	N 424	2. How will you identify of residents having the potent affected by the same allege deficient practice and what corrective action will be tated. A side r\ail audit was completed 100% of the beds in the facilitiensure there was no opportunent appearent. The audit began ended on 3/30/2012. The audit was completed by the Charge Nurses, DON, ADON Corporate Quality Assurance and the Corporate Director of Services on 3/30/2012. A total of nine beds were replosting skin assessments were completed by the charge nurses on all reside 2nd Tennessee beginning 3/30/2012 through 4/4/2012 to identify unbruises and or abrasions. • All residents on 2nd Tennesse be affected by the same alleged deficient practice. However to safe environment for all reside live on 2nd Tennessee Resident transferred to Bristol Regional Medical Center for an evaluating placement to a behavior unit of 3/30/2012 at 4:00pm.	tial to be ed t ken? ted on ty to nity for and he , Nurse, f Clinical aced. eted by ents on 2012 nknown ee may lensure a nts who #21 was len and	Completion Date Hulin
	stating that Pt was or			1			

URYC11

FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN8201 03/31/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **261 NORTH STREET BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) N 424 Continued From page 9 N 424 On 3/30/2012 members of the room. Pt replied that he was. Pt replied that he quality assurance committee, would not enter other residents' rooms...reiterated Director of Nursing, Assistant boundary issues...clarifying loneliness in (is) no Director of Nursing and or the excuse. Adequate understanding -Chief Executive, Corporate implementation remains questionable...often Director of clinical services confused w/ some illogical thinking, poor reviewed the Staffing levels on 2nd judgment, some delusions..." Tennessee and decided to increase staffing by 43% (4- staff members)

Medical record review of the Psychiatric Notes for resident #21 dated January 24, 2012, revealed. "...Staff report that resident continues his pursuit of female residents. They do not feel it is sexual but more of wanting to lay beside them probably because he misses his wife however there have been several close calls recently and staff have noticed that he will take a piece of paper or a sock and put it in the door while he is inside with a female resident, he is currently on Q-15min (every 15 minutes) checks so staff are aware of his where-abouts at all times..."

Medical record review of the Mental/Behavioral Health Progress Notes dated January 31, 2012, revealed, "...Re-emphaiszed w/ Pt the importance of not entering anyone else's room. Pt agreed..."

Medical record review of the Nurse's Notes dated February 4, 2012, at 6:25 p.m., revealed, "This resident came and told nurse that female resident was in the floor and pointed down hallway - nurse went to (check) and found female resident in her room on buttocks. Female resident said this resident (resident #21) tried to stand her (up) from side of bed and she slid to fall in floor. Residents separated. This resident (resident #21) monitored closely for wandering..."

Review of the IDT (Interdiscliplinary Team) recommendations for the incident February 4, 2012, revealed, "...Psych svc (psychiatric

on the 7A-7P shift and increased by 25% (2 staff members) on the 7P -7A shift. Staffing will be increased to six nursing assistants on the 7A-7P shift and five nursing assistants on the 7P - 7A shift as soon as the facility can maintain the new staffing levels. This will be a permanent change.

To increase and retain the increased number of staff on 2nd Tennessee the facility has placed a newspaper ad locally, on Craig's list and, on Monster.com for C.N.A'.s, LPN'.s and RN's.

Offering a \$500.00 new hire sign on Bonus for LPN's and C.N.A.'s.

Offering a \$250.00 referral Bonus to current employee that refers other nursing staff that are hired and stay past ninety days.

A perfect attendance Bonus of an additional twenty-five cent per hour worked per pay period has been implemented for nursing assistants.

All staff will receive education on:

Completin Date 4/11/12

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FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **261 NORTH STREET BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) N 424 Continued From page 10 N 424 services) to follow r/t (related to) (increased) · Managing residents with Dementia behaviors..." and Dementia related behaviors including residents who wander. Medical record review revealed no new Contracted Hospice provider is interventions were implemented for increased scheduled to provide the above supervision of resident #21. training. The training began on 4/5/2012 and will be completed by Medical record review of the Nurse's Notes dated April 11, 2012. February 5, 2012, at 4:30 p.m., revealed. • Implementation of interventions to "Resident observed via staff, hitting another in prevent a behavior. Contracted head (with) fists. Redirection provided to Hospice provider is scheduled to residents..." provide the above training. The training began on 4/5/2012 and will be Review of the IDT recommendations for the completed by April 11, 2012. incident February 5, 2012, revealed, "...Notified Implementation of interventions after Correction Date 4/1.1/2 psych svc; monitor closely..." a behavioral event has occurred. 150 1 Contracted Hospice provider is Medical record review revealed no new scheduled to provide the above interventions were implemented for increased training. The training began on supervision of resident #21. 4/5/2012 and will be completed by April 11, 2012. The training also Medical record review of the Nurse's Notes dated included a review of the facility policy February 7, 2012, at 2:10 p.m., revealed, on Behavior assessment and "Another resident reported to me that (resident monitoring by the Assistant Director of #21) slapped him across the face. They were in Nursing. the hall (long) on 2nd TN. (Resident #21) has no recollection of any events and when questioned · The Corporate Sr. Director of he repeats numerous stories about the events..." clinical Services, corporate Quality Assurance Nurse and or Director of Review of the IDT recommendations for the Nursing will educate all staff on the incident February 7, 2012, revealed, "...psych to types of abuse, the policy and follow..." procedure for reporting and investigating abuse, Sexual behaviors Medical record review revealed no new and possible sexual abuse. The interventions were implemented for increased

supervision of resident #21.

Medical record review of the Nurse's Notes dated

February 8, 2012, at 10:30 a.m., revealed, "IDT review of altercation on 2/7/12 ... MD (Medical

training began on 4/4/2012 and will

end on 4/11/2012. This training also included mandatory reporting of the

Elder Abuse Act

FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **261 NORTH STREET BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 424 Continued From page 11 N 424 Doctor) was notified. Will have psych follow..." · All staff who missed the in-service will be in-serviced by the staffing Medical record review of the Mental/Behavioral coordinator and or the corporate Health Progress Notes dated February 7, 2012. Quality assurance nurse prior to being revealed, "...(Nursing staff advised this therapist allowed to work the floor. The facilities that there had been another behavioral incident do not use agency staff. w/ patient involving another resident)...asked Pt how he was getting along w/ others...replied was doing fine...denied having any problems...denied The Director of Nursing, Assistant having any incidents or altercations w/ other 13 1 Director of Nursing and or the Chief residents...replied that he was an honest man Executive Director will investigate all and assured good behavior...not w/out (without) allegations of abuse as soon as they are confusion, and some delusional thinking at made aware of the allegation and will times..." report the allegations and the findings of the investigation to the appropriate Medical record review of the Nurse's Notes dated state agencies. February 16, 2012, at 5:00 p.m., revealed, "A 121 1 family member approached the nurses station (with) clothes in...hand and made reference that one of the residents in the dayroom took...father's clothes and stole his socks, while...attempting to write...father's name in them...said 'That man scratched me'...then identified (resident #21)..." · The interdisciplinary team Medical record review of the Social Service (Administrator, Director of Nursing, Progress Notes dated February 16, 2012, Assistant Director of Nursing, Medical revealed, "Care Plan Review...Behavior concerns Director, Business Office Manager, discussed as related to how resident wants to help others - i.e. (that is) transfers, etc. (etcetera) Dietary Manager, Activities Director, Social Services Director, and Therapy - will cont. (continue) to monitor ... " Manager) will review all allegations of abuse in the daily clinical meeting and Medical record review of the Nurse's Notes dated in the monthly Quality Assurance March 1, 2012, at 4:30 p.m., revealed, "This

resident struck male resident in his back (with) his fist (per CNA) no visible injury noted residents separated. Staff monitoring..."

Review of the IDT recommendations for the incident March 1, 2012, revelaed, "...IDT follow-up - resident attempt to harm other

meeting.

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION

(X3) DATE SURVEY COMPLETED A. BUILDING B. WING ___

	TN8201		B. WING _		03/	31/2012
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aldercation (further a	altercation) until 3-9	-12				
interventions were in	nplemented for incre	eased				
from the FNP (Famil March 7, 2012, reveal	y Nurse Practitioner aled, "Does not wa) dated ant exam!				
March 9, 2012, at 1:0 to this nurse by CNA. #21) was in dayroom male resident (reside female resident (reside - Residents separated #21) agitated and kepresident (resident #35 intervened2pm This walked up to the sam #35) and hit him with male resident (resident female resident (resident female)	70 p.m., revealed, "F This resident (resident walked up to a not #35) that was tall is resident (resident in not #35) in face (with id - this resident (resident in the trying to go toward is resident (resident in the male resident (resident in the male resident (resident in the male resident while on the #35) was at	Reported dent nother king to a #21) hit ident dent male #21) sident other with the first ident other male				
pmResident (reside ambulance to (named to (facility). DON (Dire	nt #21) transported hospital)7 pm Re ector of Nursing)	via				
Progress Notes for res 2012, "Attempted refe - transported to hospit toward another individ	sident #21 dated Ma rral to 5-E (psychiat alaggressive beha ual" Medical reco	rich 9, ric unit) avior rd				
	Continued From pagaresidentResidents aldercation (further a aggitated toward material mat	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM. Continued From page 12 residentResidents separate no futher aldercation (further altercation) until 3-9-aggitated toward male resident" Medical record review revealed no new interventions were implemented for incressupervision of resident #21. Medical record review of Daily Progress from the FNP (Family Nurse Practitioner March 7, 2012, revealed, "Does not wa Foul languageDementia (with) behavior issues" Medical record review of the Nurse's Not March 9, 2012, at 1:00 p.m., revealed, "Four to this nurse by CNA. This resident (resident #21) was in dayroom and walked up to a male resident (resident #35) that was tall female resident (resident #35) in face (with - Residents separated - this resident (resident #21) agitated and kept trying to go toward resident (resident #35) he hit - staff intervened2pm This resident (resident #35) and hit him with his fist again while of male resident (resident #35) was at elevator-residents separated by staff2:2 pmResident (resident #21) transported ambulance to (named hospital)7 pm Resident (resident #21) transported ambulance to (named hospital)7 pm Resident (resident #21) dated Mazon Medical record review of the Social Servic Progress Notes for resident #21 dated Mazon Medical record review of the Social Servic Progress Notes for resident #21 dated Mazon Medical record review of the Social Servic Progress Notes for resident #21 dated Mazon Medical record review of the Social Servic Progress Notes for resident #21 dated Mazon Medical record review of the Social Servic Progress Notes for resident #21 dated Mazon Medical record review of the Social Servic Progress Notes for resident #21 dated Mazon Medical record review of the Social Servic Progress Notes for resident #21 dated Mazon Medical record review of the Social Servic Progress Notes for resident #21 dated Mazon Medical record review of the Social Servic Progress Notes for residen	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 residentResidents separate no futher aldercation (further altercation) until 3-9-12 aggitated toward male resident" Medical record review revealed no new interventions were implemented for increased supervision of resident #21. 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AM..." vision of Health Care Facilities

Social Services notes.

Treatment - Psyc Unit." Further review revealed March 12, 2012 was the last documentation in the

Medical record review of the Nurse's Notes dated March 13, 2012, at 11:00 a.m., revealed, "...He was seen throwing a shoe at another res this

FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **261 NORTH STREET BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) N 424 Continued From page 14 N 424 Medical record review of Daily Progress Notes from the FNP dated March 13, 2012, revealed, "Pt (patient) to ER (emergency room)...severe agitation..." Medical record review revealed the ER visit was March 9, 2012, from 2:20 p.m., until 7:00 p.m. Medical record review of the Mental/Behavioral Health Progress Notes dated March 15, 2012, revealed, "...(Nursing staff requested this therapist visit w/ Patient due to some boundary issues and some behavioral problems)...Pt related getting along alright, having no problems...Since Pt denied having any problems. Confrontive Therapy necessary relative to Pt's intruding into other residents' rooms. Pt stated that he gets a little confused at times. This Thx countered w/ Pt's ability to find his own room...Pt said he would remember to do this, he added that he is a nice man and does not want to cause problems..." Medical record review of the Nurse's Notes dated March 27, 2012 at 6:30 p.m., revealed, "Res has been (up) walking around facility. Res pushing some of the women res around unit in their w/cs (wheelchairs). Res re-directed to lobby (without) difficulty. 0 (no) apparent behavior/anger problems noted...' Medical record review of the Mental/Behavioral

Health Progress Notes dated March 22, 2012. revealed, "...Pt related feeling a little anxious and depressed, stating some things were bothering him...replied that there was minor argument w/ another resident recently that had upset Pt. Pt. unable to provide much in the way of details, somewhat vague and superficial..." Review of the

Mental/Behavioral Health progress notes revealed no recommendations for staff to

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the dayroom..." Review of the IDT recommendations for the incident for March 27, 2012, revealed, "...Medication changes made...Psych services notified of behavior...IDT will follow up in 5-7

buttocks. (Resident #21) was then assisted to

Medical record review of Daily Progress Notes for resident #21 from the FNP dated March 28, 2012, revealed, "...having aggressive behaviors hitting..."

days..."

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#35)." Continued interview confirmed interventions are to separate the residents. redirect them, and talk to them about what is

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resident was having escalating aggressive behaviors the staff managed the resident's behaviors by checking where the resident was every 30 minutes and redirecting the resident to the dayroom if found in other resident's rooms. Continued interviews confirmed the resident had not been placed on one to one supervision or every 15 minute checks since "way before" the attempt at psychiatric admission March 9, 2012. Continued interviews confirmed there were times Division of Health Care Facilities

STATEMENT	OF	DEFICIENCIES
AND PLAN OF	F C	ORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

TN8201

A. BUILDING B. WING ___

03/31/2012

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BRISTOL NURSING HOME

261 NORTH STREET BRISTOL, TN 37625

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N 424	Continued From page 19	N 424		
Tw .	resident #21 needed to be on one to one supervision or every 15 minute checks, for the safety of other residents, but the unit did not always have available staff to monitor the resident more frequently than every 30 minutes. Interviews confirmed the only time nursing has called the SSD for intervention was March 9, 2012, to send the resident to the ER. Continuinterviews confirmed the resident had hit seve different male residents over the last few more Continued interviews confirmed unit manager were aware resident #21 had a physical altercation with resident #35 on March 27, 20 and no changes were made in to increase the	sident ad ued eral nths.		
	Interviews with resident #38 and LPN #7 on March 30, 2012, at 9:40 a.m., at the 2nd TN nursing station, revealed the LPN stated resid #38 (female resident) was a reliable source of information and wanted to report an incident concerning resident #21. Interview with reside #38 revealed the resident was awakened early that morning with resident #21 standing over resident #38's bed, and resident #21 "scared" resident #38 causing resident #38 to slap resident #21's arm. Resident #38 stated resident #21 came to resident #38's room "more than I like" and resident #38 stated "I don't like it." LPN # confirmed staff were unaware resident #21 has been in resident #38's room.	ent y dent 7		
	Medical record review of the an assessment for resident #38 dated February 19, 2012, reveale the resident scored 14 out of 15 on the BIMS, indicating no cognitive impairment.	ed		
	Medical record review of the Nurse's Notes for March 30, 2012, revealed resident #21 was on every 15 minute observations and the following			

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Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 261 NORTH STREET BRISTOL NURSING HOME BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 424 Continued From page 20 N 424 documentations, "...10:45A (a.m.)...Resident talking about women being with other men talking about I think my wife had 3-4 other men. Resident talking about resident female as if it was his late wife...12:00P (p.m.)...calm until meeting other male resident mumbled a few words to (resident name) then walked away..." Interview with the Activities Director (AD) on March 30, 2012, at 10:38 a.m., in the conference 1:5' 2 room, confirmed the AD had noticed resident . 1 #21's behaviors had become worse "lately" and the resident had particular issues with resident #35, who resident #21 feels is the person who assaulted him in the past. Interview confirmed 1.11 the resident picks various females and thinks they are his wife or girlfriend. Further interview 101 7 confirmed the resident had always been difficult to occupy with activities, which would sometimes work and sometimes not work, depending on the resident's mood, but the AD had noticed the resident was refusing to participate in any activities more lately. Continued interview confirmed the AD had seen the biggest change in the last week and "This is the worse I have seen him." Observation of resident #21 and interview with the Assistant Director of Nursing (ADON) and Corporate Quality Assurance Nurse on March 30. 2012, from 3:51 p.m., until 4:02 p.m., on 2nd Tennessee, confirmed resident #21 had been on one to one or every 15 minute checks since 10:30 a.m., and was currently on one to one supervision, due to safety concerns for the other residents, and the resident was transferred to the hospital at 4:02 p.m., for evaluation and treatment of behaviors. Interview with CNA #1 on March 30, 2012, at 4:15

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Division of Health Care Facilities

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

TN8201

A. BUILDING
B. WING _____

03/31/2012

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BRISTOL NURSING HOME

261 NORTH STREET BRISTOL, TN 37625

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PRECEDE	FULL P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 424	Continued From page 21	N.	424		
N 424	p.m., outside the 2nd TN shower rooms, confirmed "they all wander, they don't know where they are" and staff redirect the result of Telephone interview with the Psychiatric Practitioner (NP) on March 30, 2012, at 4 p.m., confirmed the NP had been treating resident #21 in conjunction with a clinical psychologist since the resident's ex-spour in November, 2011. Continued interview	ow idents. Nurse ::45 J	424		
	confirmed they were unsure if the psychologist provided the progress reports so the NP could manage medications. Continued interview confirm resident suffered a very accelerated decline which the resident was more confused, so aggressive, was going into other resident rooms, and was aggressive towards male Continued interview confirmed the NP had informed the resident had "Last night" gor resident's room and slapped, kicked, and a resident. Continued interview confirmed the resident wanting to be with residents and kiss female residents. Continued interview confirmed the one incident in January when the resident was found in bed with a female resident was found in bed with a female resident work fully clothed and he with his pants off and underwear on. Continued interview confirmed the NP thought medic such as being found in the female resident room "with a sock placed in the door jam." Interview confirmed the NP thought medic interview confirmed the resident was the province of the NP thought medic interview confirmed the resident was the province of the NP thought medic interview confirmed the resident was the new to show symptom improvement and the NP thought medic interview to show symptom improvement and the NP thought medic interview to show symptom improvement and the NP thought medic interview confirmed the resident was the new to show symptom improvement and the NP thought medic interview confirmed the resident was the new threat the nP thought medic interview confirmed the nP ps	ided NP with ened the ned the ne in exually s. d been ne into a pushed d when aviors female tinued iar with lent ith her med the iors t's ation e sexual nonths nd "you			

Divisio	n of Health Care Fac	ilities				FORM	APPROVED
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N 424	Continued From page	ge 22		N 424			
	had altercations and towards other male interview confirmed other residents until effect.	d physical aggressive residents. Continue needed supervision	d to protect				
48 1 16 2 4 4	Telephone interview on March 30, 2012, resident had been "i physician had on two resident to the emer and admission to a president was returne admitted. Further in physician had been admitted to a psychiamore intense monito behaviors. Continue needed "to keep an resident was violent. confirmed the physician to one to one observati down, which would be resident.	at 6:20 p.m., confirm ntermittently violent" o other occasions se gency room for evaluation osychiatric unit, but the dot the facility withouterview confirmed the trying to have the rest atric unit due to the rest atric unit due to the rest atric unit due to the rest of interview confirmed eye on him" when the Continued interview cian thought the nurse on at least every 15 mons until the resident	ned the and the and the uation he being e sident need for nt of d staff e v es ninute or t calmed				
	Interviews with the S the Senior Director o March 30, 2012, at 1 Director of Nursing (/ facility staff were awa aggressive behaviors residents including re interviews confirmed resident were to be d the resident was capa	f Clinical Operations 0:45 a.m., in the Ass ADON's) office, confiare of resident #21's and having hit othe esident #35. Continution visual checks to location	on distant dirmed r dued ate the				

residents was capable of fiditing official residents in a thirty minute time frame. Continued interviews confirmed the facility had just implemented every 15 minute monitoring to ensure the safety of other residents.

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chair...stating these people aren't paying their dues..." Continued medical record review revealed the facility provided no increased

supervision for the resident (#35).

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behaviors for the resident.

Observation on March 26, 2012, at 10:00 a.m., revealed the resident standing at the 2nd

Tennessee Nurse's Station, confused, with a clip

board in hand, making a statement about something that had not been done.

Observation on March 27, 2012, at 3:00 p.m.,

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for activities of daily living.

Observation of the resident on March 27, 2012, at 3:54 p.m., in the resident's room, and interview with LPN #4, in the resident's room, confirmed the resident was lying in bed, and the full bed rails of the bed, which were both elevated, shifted at the foot of the bed causing a gap between the resident's mattress and the bed rails. Continued

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Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN8201		(X2) MUL A. BUILDI B. WING		(X3) DATE S COMPL	ETED		
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N 424	Continued From page observation and interpretation and interpretation and interpretation of approximately "hand fingertip to base of proving them of the pressure was moving them. Further resident was capabled feet in the bed and the for the resident. Interpretation of the resident would immediately.	erview confirmed the the mattress and bed size" (measuring froalm) and the gap create left or right side applied to the bed rater interview confirmed of the moving the left gap was a safety erview confirmed	or ail was om eated of the ails, ed the legs and	N 424			
	Observation of the reservation in the resiresident was lying in on both sides of the of the bed was elevated degrees. The reside left side, against the observation revealed compressed the matthe bed elevated, a gof the mattress and the bars was large enough the shoulder area to Further observation of the bed was still pushifted as observed as	ident's room, revealed bed, sleeping, full bed were elevated, the steep approximately 4 and was leaned toward side rails. Further at the weight of the restress, and with the happed created between the space in the full sight for the resident's fit through the space revealed the gap at the resent and the bed reserved.	ed the ed rails the head 5 ds the sident ead of the top side rail arm to e. he foot				
	Observation and inte Director of Clinical So at 8:26 p.m., in the re bed rails were a safe removed. Resident #17 was ad October 28, 2011, wi Intracranial Injury, Fa	ervices on March 27 esident's room, confi ty risk and were imm lmitted to the facility th diagnoses including	, 2012, rmed the nediately on				

Abnormality of Gait, Muscle Weakness, Failure to

PRINTED: 04/10/2012 FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 261 NORTH STREET **BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Continued From page 27 N 424 N 424 Thrive, and Senile Cachexia. Medical record review of the Minimum Data Set (MDS) dated January 22, 2012, revealed the resident required extensive assistance with 1 1 decision making, had short and long term memory loss, and was totally dependent for activities of daily living. Observations on March 26, 2012, at 2:52 p.m., DV S 3:00 p.m., 4:18 p.m., and 4:23 p.m., March 28, 2012, at 2:15 p.m., and March 29, 2012, at 8:00 a.m., 8:38 a.m., and 1:44 p.m., revealed the resident was constantly rolling in and out of other resident's rooms without redirection or being engaged in any activity by staff. Put 1 Observation on March 26, 2012, at 3:01 p.m. to 3:06 p.m., revealed the resident was in another resident's room with the door shut. Continued iti i observation revealed the resident was sitting in a wheelchair with the bottom drawer of the bedside table belonging to the resident in B bed opened. Continued observation revealed resident #17 retrieving another resident's jewelry from a bedside table and placing it on the left ankle. Interview with Certified Nursing Assistant (CNA) #1 on March 26, 2012, at 3:10 p.m., on 2nd Tennessee hallway, stated the resident would be taken to the second floor day room, "like I have

done ten times today".

Observation at that time revealed the resident was rolled out of the room and placed in the middle of the 2nd Tennessee day room by CNA #1, where the wheelchair was locked. CNA #1 exited the day room and the resident was not engaged in any activity with no staff present.

PRINTED: 04/10/2012 FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 261 NORTH STREET **BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 424 Continued From page 28 N 424 Observation on March 26, 2012, at 3:19 p.m., in the 2nd Tennessee day room, revealed the resident sitting in a wheelchair with the shirt off and no bra on and no staff was present. Observation on March 26, 2012, at 4:23 p.m., revealed resident #17 was coming out of another resident's room and the staff redirected the resident toward the second floor nurses station. Continued observation revealed the resident then turned the wheelchair around and rolled into -1 another resident's room and the resident in that room told the resident to "go out". Observation on March 27, 2012, at 8:00 p.m., revealed resident #17 going into another resident's room, turning overhead lights on, 74 1 pushing bed of the resident against the wall, while 71 this resident was lying in the bed asleep. Continued observation revealed the resident exited that room and went into another resident's room where this resident called out in a loud voice, "get (resident) out of here". Continued observation revealed the resident was taken to the 2nd Tennessee day room and not engaged in any activity and was left unattended. Continual observation of the 2nd Tennessee unit on March 29, 2012, from 7:32 a.m. to 7:46 a.m., revealed the resident was not in resident's room, hallways, shower room, or day room. Continued observation revealed staff was unaware of where the resident was and was unable to locate the

resident.

Observation and interview on March 29, 2012, at 7:46 a.m., revealed Licensed Practical Nurse (LPN) #7 located the resident in another

resident's room. Continued observation revealed the resident sitting in a wheelchair with the head

Divisio	on of Health Care Fac	ilities				FOR	M APPROVE
STATEME AND PLAN	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/CLIA IMBER:	Office and and	MULTIPLE CONSTRUCTION ILDING	(X3) DATE SURVEY COMPLETED	
NAME OF	PROVIDER OR SUPPLIER	TN8201	STREET			03/	31/2012
	L NURSING HOME		261 NOR	RTH STRE L, TN 376	TY, STATE, ZIP CODE EET 25		(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMA	FIIII	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
	Continued From pag lying on bed of the re observation revealed staff into the short had or engaged in any act was unaware of whele finding the resident in and "this was a conce	esident in B bed. Con I the resident was rol allway and was not re ctivity. LPN.#7 confirm re the resident was p	lled by edirected ned staff	N 424			-
N 602 (r ii 1 1 c a a T B received and a a g (#2 Th As a do of r	1200-8-606(1)(b)1. In (1) Performance Imposition (b) The performance must be ongoing and implementation which the All organized service are, including service are evaluated; This Rule is not met a assed on medical reconstruction of facility documents of facility policy, sourance (QA) prografective systems were evestigate incidents of expetrated by one resind implement a behave sident (#21) with behave the programment of the facility's failure to end and #35) with behave the facility's failure to end the surance Committee in the properties of the plans were implement of the plans w	Basic Services rovement. improvement progra have a written plan of assures that: ices related to reside is furnished by a const service, observation interview,	ent tractor, on, and ate	N 602	The following corrective action is completed for each resident four have been affected by the alleged deficient practice • On 3/30/2012 members of the quality assurance committeed Director of Nursing, Assistated Director of Nursing and the Executive Officer, Corporated Director of clinical services as Corporate Quality Assurance Nurse had an informal quality assurance meeting to develop plan to stop the immediacy of Jeopardy. The following plan put in place: • The Staffing levels on 2 nd Tennessee were increase staffing by 43% (4- staff members) on 7A-7P shift and increased by 2 (2 staff members) on the 7P -7 shift.	ne ee, nt Chief ee ty o a f the was	

FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **261 NORTH STREET BRISTOL NURSING HOME** BRISTOL, TN 37625 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) N 424 Continued From page 29 N 424 Staffing will be increased to six lying on bed of the resident in B bed. Continued nursing assistants on the 7A-7P observation revealed the resident was rolled by shift and five nursing assistants on staff into the short hallway and was not redirected the 7P - 7A shift as soon as the or engaged in any activity. LPN #7 confirmed staff facility can maintain the new was unaware of where the resident was prior to staffing levels. This will be finding the resident in another resident's room permanent staffing. and "this was a concern". The DON, ADON, Corporate Quality Assurance Nurse, 1200-8-6-.06(1)(b)1. Basic Services Corporate Sr. Director of Clinical N 602 N 602 Services and unit managers assessed all side rails in the facility (1) Performance Improvement. to ensure there was no one at risk of entrapment. (b) The performance improvement program must be ongoing and have a written plan of Nine beds were replaced with new implementation which assures that: beds. Skin assessments were completed 1. All organized services related to resident by the charge nurses to identify care, including services furnished by a contractor. unknown bruises and or abrasions. are evaluated: Resident # 21 was placed on fifteen This Rule is not met as evidenced by: minute observation on 3/30/2012 at Based on medical record review, observation. 10:30 am until he was transferred to review of facility documentation, interview, and another facility. review of facility policy, the facility Quality Assurance (QA) program failed to ensure · Resident #21 was transferred to the effective systems were in place to identify and Medical Center for an Evaluation and investigate incidents of abuse allegedly placement to a behavior unit on perpetrated by one resident (#21); to formulate 3/30/2012 at 4:00pm. The facility will and implement a behavior care plan for one not readmit this resident. resident (#21) with behaviors; and failed to identify staffing needs to provide supervision of · The care plan was updated for res. # aggressive/abusive behaviors for two residents 35 by social services, MDS (#21 and #35) with behavioral problems. Coordinator, Social Services, Quality

The facility's failure to ensure the Quality

Assurance Committee identified issues and

of possible abuse were investigated; behavior

addressed plans of correction to ensure incidents

care plans were implemented; and supervision of

behaviors.

Assurance Nurse and Sr. Director of

the need to notify the MD and social

services of changes in mood and

clinical services on 03/31/2012 to reflect

Division of Health Care Facilities

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIE		(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
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		TN8201				03	/31/2012
NAME OF	PROVIDER OR SUPPLIER		12-24-14-16-16-16-16-16-16-16-16-16-16-16-16-16-		STATE, ZIP CODE		
BRISTO	L NURSING HOME			TH STREET , TN 37625		₫.	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
	lying on bed of the re observation revealed staff into the short had or engaged in any adwas unaware of whe finding the resident if and "this was a conditional "this was a co	esident in B bed. Cod the resident was reallway and was not rectivity. LPN.#7 confirere the resident was nanother resident's period and the resident's period and the resident's period and the resident's period and the resident	edirected med staff prior to room ram of dent entractor, and and eulate ne con of	N 424	• The care plan for resident # updated on 4/2/2012 with the finterventions: place the reside to one observation when he dis aggressive behaviors toward or residents and, notify the MD asservices when the resident dispaggressive behaviors toward or residents. The charge nurse wimmediately notify the MD anservices if or when the resident displays aggressive behaviors. Resident # 35 was seen by Psyc Services on 3/27/2012 related to aggressive behaviors. The follo Recommendations were made Psych. Services during the last Increase Exelon Patch to 9.5 m hrs, topically for maximum cogbenefit. Increase Seroquel XR at 5 pm daily for agitation and combative behavior. • On 3/31/2012 the social worked completed a PHQ9 assessment or resident's # 17; #32; #35; # 36 as a service of the resident's # 17; #32; #35; # 36 and the resident's # 17; #32;	following nt on one splays ther nd social blays ther ill d social t chiatric o recent wing by visit. g/24 mitive 400 mg	
	The facility's failure to Assurance Committee addressed plans of co of possible abuse wer care plans were imple	e identified issues an prrection to ensure in e investigated; beha	cidents vior				

Division of Health Care Facilities

STATEMENT	OF DEFICIENCIES
AND PLAN OF	CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

TN8201

A. BUILDING B. WING ___

03/31/2012

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BRISTOL NURSING HOME

261 NORTH STREET BRISTOL, TN 37625

BRISTO	DL NURSING HOME		, TN 37625		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 424	lying on bed of the resident in B bed. Cor observation revealed the resident was rol staff into the short hallway and was not re or engaged in any activity. LPN:#7 confirm was unaware of where the resident was p finding the resident in another resident's reand "this was a concern".	led by directed ned staff rior to	N 424	to identify possible changes in signs and symptoms of mood distress since the residents last OBRA or PPS assessment. The assessments revealed that there was no change from the baseline on seven of the eight residents assessed. (The PHQ-9 is a 9 item patient health questionnaire. A validated interview	
N 602	(1) Performance Improvement. (b) The performance improvement programust be ongoing and have a written plan of implementation which assures that:	f	N 602	that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder. The total severity provides a standard of communication with clinicians and mental health specialist.)	
	1. All organized services related to reside care, including services furnished by a con are evaluated; This Rule is not met as evidenced by: Based on medical record review, observation review of facility documentation, interview, a review of facility policy, the facility Quality Assurance (QA) program failed to ensure effective systems were in place to identify a investigate incidents of abuse allegedly perpetrated by one resident (#21); to formulate and implement a behavior care plan for one resident (#21) with behaviors; and failed to identify staffing needs to provide supervision aggressive/abusive behavioral problems. The facility's failure to ensure the Quality Assurance Committee identified issues and addressed plans of correction to ensure incident of possible abuse were investigated; behaviorate plans were implemented; and supervisite are plans were implemented.	on, and ate of onts		• On 3/31/2012 Resident #36 showed a change from her previous assessment. During the assessment this resident stated that this is not a good time for her, she is having problems with her daughter and at times she has thoughts that she would be better off dead. The resident stated no when the social worker asked her if she had a plan to harm herself. The social worker notified the nurse of the residents' statement. The nurse notified the MD and obtained an order for a Psychiatric evaluation on 3/31/2012. The nursing staff observed the resident through out the night and Completed thirty minutes observations until the resident was seen by psychiatric services.	

FORM APPROVED Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING TN8201 03/31/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 261 NORTH STREET BRISTOL NURSING HOME BRISTOL, TN 37625 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) N 424 N 424 Continued From page 29 A Psychiatric note dated 4/3/2012 lying on bed of the resident in B bed. Continued reveals that resident #36 adamantly observation revealed the resident was rolled by denies any thoughts, plans or intent of staff into the short hallway and was not redirected self harm stating "I could never do or engaged in any activity. LPN #7 confirmed staff that, I have just been sadder lately". was unaware of where the resident was prior to 11. j finding the resident in another resident's room · The M.D was notified and agreed to and "this was a concern". the recommendations for Medication changes and the discontinuation of the N 602 frequent checks for res. #36. . N 602 1200-8-6-.06(1)(b)1. Basic Services Performance Improvement. · A skin assessment was completed on resident's # 17; #32; #35; # 36 and #37 to identify the presence of bruising and (b) The performance improvement program or redness. There were no bruising or must be ongoing and have a written plan of • • redness of unknown causes identified implementation which assures that: on any of the residents. 11/2 All organized services related to resident care, including services furnished by a contractor, are evaluated: · Care plans were updated on resident on resident # 17; 32; ; #35; #36and #37 Coupleton Date This Rule is not met as evidenced by: by social services, MDS Coordinator, Based on medical record review, observation, Quality Assurance Nurse and Sr. review of facility documentation, interview, and Director of clinical services on review of facility policy, the facility Quality 03/31/2012 to reflect the need to notify Assurance (QA) program failed to ensure the MD and social services of changes effective systems were in place to identify and in mood and behaviors. investigate incidents of abuse allegedly • The care plan for Resident # 36 care perpetrated by one resident (#21); to formulate plan was updated by social services, and implement a behavior care plan for one MDS Coordinator Quality Assurance resident (#21) with behaviors; and failed to Nurse and Sr. Director of clinical identify staffing needs to provide supervision of services on 03/31/2012 with refer to aggressive/abusive behaviors for two residents Psych services and monitor every (#21 and #35) with behavioral problems. thirty minutes until evaluated by

The facility's failure to ensure the Quality Assurance Committee identified issues and addressed plans of correction to ensure incidents of possible abuse were investigated; behavior care plans were implemented; and supervision of

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psych. Services.

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **261 NORTH STREET BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 424 Continued From page 29 N 424 On 4/3/2012 the care plan was lying on bed of the resident in B bed. Continued updated with the discontinuation of the observation revealed the resident was rolled by fifteen to thirty minute observations staff into the short hallway and was not redirected for res. # 36. or engaged in any activity. LPN #7 confirmed staff The M.D was notified and agreed was unaware of where the resident was prior to with recommendations from finding the resident in another resident's room psychiatric services for Medication and "this was a concern". changes and the discontinuation of the frequent checks on 4/3/2012. N 602 1200-8-6-.06(1)(b)1. Basic Services N 602 The staff discontinued the frequent checks as ordered. Performance Improvement. (b) The performance improvement program must be ongoing and have a written plan of implementation which assures that: 2. How you will identify other residents 1. All organized services related to resident having the potential to be affected by the care, including services furnished by a contractor, same alleged deficient practice are evaluated: 4, . and what corrective action will be taken This Rule is not met as evidenced by: All residents on 2nd Tennessee may be Based on medical record review, observation. affected by the same alleged deficient review of facility documentation, interview, and practice. To prevent a reoccurrence of review of facility policy, the facility Quality this alleged deficient practice the Assurance (QA) program failed to ensure following changes has been effective systems were in place to identify and implemented. investigate incidents of abuse allegedly perpetrated by one resident (#21): to formulate On 3/30/2012 members of the and implement a behavior care plan for one quality assurance committee, resident (#21) with behaviors; and failed to Director of Nursing, Assistant identify staffing needs to provide supervision of Director of Nursing and or the aggressive/abusive behaviors for two residents Chief Executive, Corporate (#21 and #35) with behavioral problems. Director of clinical services reviewed the Staffing levels on 2nd The facility's failure to ensure the Quality Tennessee and decided to increase Assurance Committee identified issues and staffing by 43% (4- staff members addressed plans of correction to ensure incidents resulting in a 1C.N.A to 7 of possible abuse were investigated; behavior

care plans were implemented; and supervision of

FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 261 NORTH STREET **BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) N 424 Continued From page 29 N 424 lying on bed of the resident in B bed. Continued residents) on the 7A-7P shift and observation revealed the resident was rolled by increased by 25% (2 staff members staff into the short hallway and was not redirected resulting in 1 C.N.A. to 8 residents or engaged in any activity. LPN #7 confirmed staff) on the 7P -7A shift. Staffing will was unaware of where the resident was prior to be increased to six nursing finding the resident in another resident's room assistants on the 7A-7P shift and and "this was a concern". five nursing assistants on the 7P -7A shift as soon as the facility can N 602 1200-8-6-.06(1)(b)1. Basic Services N 602 maintain the new staffing levels. 14 1 This will be permanent staffing. Performance Improvement. Staffing will be increased to six (b) The performance improvement program nursing assistants on the 7A-7P must be ongoing and have a written plan of shift and five nursing assistants on implementation which assures that: the 7P - 7A shift as soon as the facility can maintain the new staffing levels. 1. All organized services related to resident care, including services furnished by a contractor. are evaluated; · To increase and retain the increased number of staff on 2nd Tennessee the facility has implemented the following: This Rule is not met as evidenced by: · Placed a newspaper ad locally, online Based on medical record review, observation, advertisement for C.N.A'.s, LPN'.s and review of facility documentation, interview, and RN's. review of facility policy, the facility Quality · Offering a \$500.00 new hire sign on Assurance (QA) program failed to ensure Bonus for LPN's and C.N.A.'s. effective systems were in place to identify and • Offering a \$250.00 referral Bonus to investigate incidents of abuse allegedly current employee that refers other perpetrated by one resident (#21); to formulate nursing staff that are hired and stav and implement a behavior care plan for one past ninety days. resident (#21) with behaviors; and failed to · A perfect attendance Bonus of an identify staffing needs to provide supervision of additional twenty-five cent per hour aggressive/abusive behaviors for two residents worked per pay period has been (#21 and #35) with behavioral problems. implemented for nursing assistants. The facility's failure to ensure the Quality Assurance Committee identified issues and addressed plans of correction to ensure incidents

of possible abuse were investigated; behavior care plans were implemented; and supervision of

Division of Health Care Facilities

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		TN8201		B. WING		03/	31/2012
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE	00,1	01/2012
BRISTO	L NURSING HOME			TH STREET TN 37625			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
N 424	Continued From page	ge 29		N 424			
မည့် န	lying on bed of the robservation revealed staff into the short hor engaged in any awas unaware of whe finding the resident if and "this was a condition."	d the resident was ro allway and was not r ctivity. LPN:#7 confir ere the resident was in another resident's	edirected med staff prior to		All staff will receive education managing residents with Deme and dementia related behavior Corporate Hospice provider A 2012. The training also include review of the facility policy on Behavior assessment and monit by the Assistant Director of Nu	entia s. pril 11, d a toring	
N 602	1200-8-606(1)(b)1.	Basic Services		N 602		Ü	
	(b) The performance must be ongoing and implementation whice1. All organized ser	he performance improvement. the performance improvement program be ongoing and have a written plan of mentation which assures that: If organized services related to resident including services furnished by a contractor,			• All staff will receive educat the types of abuse, the polic procedure for reporting an investigating all incidents of abuse, Sexual behaviors and possible sexual abuse by the Senior Director of Clinical Services with Health Service management group, the Quances	ey and d f d es es	
N. 3	This Rule is not met Based on medical recreview of facility docureview of facility policical Assurance (QA) progeffective systems were investigate incidents of perpetrated by one reand implement a behave sident (#21) with behave identify staffing needs aggressive/abusive be (#21 and #35) with behave addressed plans of coof possible abuse were care plans were implested.	cord review, observa- imentation, interview y, the facility Quality ram failed to ensure re in place to identify of abuse allegedly esident (#21); to form avior care plan for or ehaviors; and failed to to provide supervisi- ehavioral problems. The ensure the Quality e identified issues and prrection to ensure in the investigated; beha	and ulate ne o on of dents nd cidents		Director of Nursing by Ap. 2012. This training also in mandatory reporting of El Abuse Act • The Director of Nursing, Assis Director of Nursing and the Chi Executive officer (Administrator investigate all allegations of abus soon as they are made aware of allegations and will report the allegations and the findings of the investigation to the appropriate agencies.	cluded der stant ef r) will se as the	

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **261 NORTH STREET BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 424 Continued From page 29 N 424 The interdisciplinary team lying on bed of the resident in B bed. Continued (Administrator, Director of Nursing, observation revealed the resident was rolled by and Assistant Director of Nursing, staff into the short hallway and was not redirected **Business Office Manager**, Dietary or engaged in any activity. LPN.#7 confirmed staff Manager, Activities Director, Social was unaware of where the resident was prior to Services Director, and Therapy ng. finding the resident in another resident's room Manager) will review all allegations of and "this was a concern". abuse in the daily clinical meeting Monday through Friday and in the N 602 1200-8-6-.06(1)(b)1. Basic Services monthly Quality Assurance meeting. N 602 The Interdisciplinary Team Performance Improvement. (Administrator, Director of Nursing, (b) The performance improvement program and Assistant Director of Nursing, Business Office Manager, Dietary must be ongoing and have a written plan of implementation which assures that: Manager, Activities Director, Social Services Director, and Therapy 11 1. All organized services related to resident Manager) met on 4/5 /2012 and was inserviced on types of abuse, the policy care, including services furnished by a contractor, and procedure for reporting and ١., are evaluated: investigating all incidents of abuse, Sexual behaviors and possible sexual abuse by the Quality Assurance Nurse This Rule is not met as evidenced by: and the Director of Nursing. This Based on medical record review, observation, training also included mandatory review of facility documentation, interview, and review of facility policy, the facility Quality reporting of Elder Abuse Act Assurance (QA) program failed to ensure effective systems were in place to identify and · The Administrator conducted an ininvestigate incidents of abuse allegedly perpetrated by one resident (#21); to formulate service with the Quality and implement a behavior care plan for one Assurance/Performance Improvement resident (#21) with behaviors; and failed to Committee members (Administrator, identify staffing needs to provide supervision of Director of Nursing, Assistant Director aggressive/abusive behaviors for two residents of Nursing, Medical Director, Business (#21 and #35) with behavioral problems. Office Manager, Dietary Manager, Activities Director, Social Services The facility's failure to ensure the Quality Director, Therapy Manager) on 04/04/2012 for the purpose of Assurance Committee identified issues and addressed plans of correction to ensure incidents reviewing federal regulation F520 of possible abuse were investigated; behavior related to Quality Assessment and

care plans were implemented; and supervision of

Assurance.

Division of Health Care Facilities

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILD	1939any	(X3) DATE SURVEY COMPLETED	
		TN8201		B. WING		03/	31/2012
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY	, STATE, ZIP CODE		
			261 NORTI BRISTOL,				
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
N 602 1 ((In nir 1 ca T B record in pear red age (# The age of th	observation revealed staff into the short had been considered in any adward of whe finding the resident in and "this was a conduction of the performance Implementation which is a conduction of the performance in the perfor	esident in B bed. Cod the resident was reallway and was not rectivity. LPN.#7 confirere the resident was in another resident's cern". Basic Services provement. e improvement progrative a written planth assures that: vices related to resident's ces furnished by a code as evidenced by: cord review, observation, interview y, the facility Quality ram failed to ensure re in place to identify of abuse allegedly esident (#21); to form avior care plan for outless to provide supervise thaviors; and failed to sto provide supervise thaviors for two resident problems.	entinued olled by edirected med staff prior to room ram of dent entractor, and entlate ne or ion of dents and entlate ne or ion of dents or ion of dents	N 424	 Absent members of Quality Assurance Committee will be in serviced prior to working by the Administrator. Facility does not agency staff. The Director of Nursing; Assist Director of Nursing; Staff Development Coordinator and Quality Assurance Nurse will pre-education to all licensed nursing Physician notification hypo / hyperglycemic blood sugnesults by April 11th, 2012. The Director of Nursing; Assist Director of Nursing; Staff Development Coordinator and Quality Assurance Nurse will pre-education to all licensed nursing regarding timely notification of Psychiatric recommendations to attending Physicians. The Unit Managers will audit diabetic flow records daily beging 4/10/2012 to ensure Physician notification of hypo /hyperglyce episodes is documented on the B sugar flow sheets. The weekend Manager will complete the daily on Saturday and Sunday. Daily audits will be completed four weeks then, Three times a v for four weeks and then, weekly four weeks and then PRN. 	istant or the rovide ses n of sar istant or the rovide ses of the the nning mic slood Nurse audits daily veek	

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDI			(X3) DATE SURVEY COMPLETED	
		TN8201		B. WING		03/	31/2012
	PROVIDER OR SUPPLIER L NURSING HOME		261 NOR	DRESS, CITY, TH STREET , TN 37625		1	V.
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
N 424	Continued From page lying on bed of the reposervation revealed staff into the short here of engaged in any awas unaware of whe finding the resident if and "this was a condition."	esident in B bed. Co d the resident was ro allway and was not r ctivity. LPN:#7 confir ere the resident was in another resident's	olled by edirected med staff prior to	N 424	 The Unit managers will refindings to the interdisciplin in the daily clinical meeting. DON/ADON will maintain a tools in the survey readiness the DON's office. The DON/ ADON and or (Assurance Nurse will audit 1) 	ary team The Il Audit binder in Duality	
N 602	1200-8-606(1)(b)1.(1) Performance Im(b) The performance must be ongoing and implementation which	provement. e improvement prog d have a written plan		N 602	the diabetic flow sheets weel ensure Physician notification hyperglycemic episodes has be documented on the blood sug sheets. Audits will be completed for eight weeks and then PRI	cly to of hypo / oeen gar flow ted weekly	
	All organized services related to resident care, including services furnished by a contractor, are evaluated; This Rule is not met as evidenced by:				 The DON and or ADON we Psychiatric consultation note each visit to ensure recommender for medication adjustments at to the Physician in a timely re 	es after endations are called	
R. 4	Based on medical recreview of facility docureview of facility policy. Assurance (QA) progreffective systems were investigate incidents of perpetrated by one reand implement a behavior (#21) with behavior identify staffing needs aggressive/abusive but (#21 and #35) with behavior in the staffing needs aggressive/abusive but (#21 and #35) with behavior in the staffing needs aggressive/abusive but (#21 and #35) with behavior in the staffing needs aggressive/abusive but (#21 and #35) with behavior in the staffing needs aggressive/abusive but (#21 and #35) with behavior in the staffing needs aggressive/abusive but (#21 and #35) with behavior in the staffing needs aggressive/abusive but (#21 and #35) with behavior in the staffing needs aggressive/abusive but (#21 and #35) with behavior in the staffing needs aggressive/abusive but (#21 and #35) with behavior in the staffing needs aggressive/abusive but (#21 and #35) with behavior in the staffing needs aggressive/abusive but (#21 and #35) with behavior in the staffing needs aggressive/abusive but (#21 and #35) with behavior in the staffing needs aggressive/abusive but (#21 and #35) with behavior in the staffing needs aggressive/abusive but (#21 and #35) with behavior in the staffing needs aggressive/abusive but (#21 and #35) with behavior in the staffing needs aggressive/abusive but (#21 and #35) with behavior in the staffing needs aggressive/abusive but (#21 and #35) with behavior in the staffing needs aggressive/abusive but (#21 and #35) with behavior in the staffing needs aggressive/abusive but (#21 and #35) with behavior in the staffing needs aggressive/abusive but (#21 and #35) with behavior in the staffing needs aggressive/abusive but (#21 and #35) with behavior in the staffing needs aggressive/abusive aggressive/abusive	umentation, interview by, the facility Quality gram failed to ensure re in place to identify of abuse allegedly esident (#21); to form avior care plan for of ehaviors; and failed to s to provide supervis ehaviors for two resi	y and y and nulate ne o ion of		 The DON/ ADON and or (Assurance Nurse will audit 1 the Psychiatric notes and the record to ensure the physicia notified of recommendations medication changes from Psy services. Audits will be comp weekly for eight weeks and the biweekly for eight weeks and PRN. 	00% of medical in is for vehiatric leted nen then	
	The facility's failure to Assurance Committee addressed plans of coof possible abuse were are plans were imple	ensure the Quality e identified issues a prrection to ensure in re investigated; beha	ncidents evior		 The DON/ADON will report findings to the interdisciplina in the monthly Quality Assur- Committee meeting until syste compliance is achieved. 	ry team ance	<i>x</i>

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FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN8201 03/31/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **261 NORTH STREET BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 424 Continued From page 29 N 424 • The MDS Coordinators were relying on bed of the resident in B bed. Continued educated on OBRA required MDS observation revealed the resident was rolled by assessments and facility required staff into the short hallway and was not redirected quarterly assessments, care plan or engaged in any activity. LPN #7 confirmed staff development and implementation by was unaware of where the resident was prior to the Quality assurance Nurse on yr.,; . finding the resident in another resident's room 4/5/2012. and "this was a concern". · The interdisciplinary team (Administrator, Director of Nursing, N 602 1200-8-6-.06(1)(b)1. Basic Services N 602 and Assistant Director of Nursing, **Business Office Manager, Dietary** Manager, Activities Director, Social Performance Improvement. Services Director, and Therapy Manager) will receive education on (b) The performance improvement program OBRA required MDS assessments and must be ongoing and have a written plan of facility required quarterly assessments, implementation which assures that: care plan development and implementation by the Quality All organized services related to resident assurance Nurse by 4/10/2012. care, including services furnished by a contractor. are evaluated: · All licensed nurses will receive education on developing Interim care plans for new admissions by 4/11/2012. This Rule is not met as evidenced by: The Quality Assurance Nurse, Director Based on medical record review, observation, of Nursing, Assistant Director of review of facility documentation, interview, and Nursing and or the staff development review of facility policy, the facility Quality Coordinator will provide the Assurance (QA) program failed to ensure education. effective systems were in place to identify and investigate incidents of abuse allegedly perpetrated by one resident (#21); to formulate • The Director of Nursing, Assistant Director of Nursing, and unit and implement a behavior care plan for one resident (#21) with behaviors; and failed to managers will review medical records identify staffing needs to provide supervision of aggressive/abusive behaviors for two residents (#21 and #35) with behavioral problems. of new admissions in the daily clinical

The facility's failure to ensure the Quality

Assurance Committee identified issues and

of possible abuse were investigated; behavior care plans were implemented; and supervision of

addressed plans of correction to ensure incidents

meeting Monday through Friday to

implemented within twenty-four hours

ensure an interim care plan is

of admission to the facility.

Division of Health Care Facilities

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
uaa ma		TN8201	11	B. WING_		03/31/2	2012
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
BRISTO	L NURSING HOME		261 NORT BRISTOL,	H STREET TN 37625			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE ((X5) COMPLETE DATE
N 602	Continued From pa	ge 30		N 602			
	residents with aggressive behaviors was provided placed all the residents on the 2nd Tennessee (2nd TN) unit in an environment which was detrimental to their health, safety and welfare.						
8	The findings include	ed:				1	
#22 1 ** /							
10 7	identify any issues requiring a corrective action plan or Performance Improvement project to address behavior issues, supervision, or identification, reporting and investigating incidents/abuse.		ct to		1. What corrective actions(s) wil	I he	
31	Refer to 1200-8-60)4 (15) (N-424) Admi	nistration		accomplished for those residents to have been affected by the alle deficient practice?	s found	13
N 669	1200-8-606(4)(c)4.	Basic Services		N 669	dencient practice:	A	mpleto
	(4) Nursing Service				 The physician was notified of residents' blood sugar results of 		Date
	(c) The Director of I following responsibil		ie		3/16/2012 and 476 on 3/23/2012 unit manager on 1 st Tennessee o	by the n	4/11/12
	4. Notify the reside medically indicated.	ent 's physician wher	1		4/09/2012. There were no new or given.	rders	
	This Rule is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to notify the physician of significant behaviors for one resident (#21); failed to notify the physician of a significant incident for one resident (#32); and failed to notify the physician of elevated blood sugars, and				• The Physician was notified by ADON on February 14, 2012 of recommendation to increase Bus from 10mg every day to 7.5 TID ADON obtained an order for the recommended change.	the spar . The	

PRINTED: 04/10/2012 FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING TN8201 03/31/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **261 NORTH STREET BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 669 N 669 Continued From page 31 psychiatric recommendation for one resident (#9) Resident # 21 was placed on fifteen of thirty-nine residents reviewed. minute observation by the Corporate Sr. Director of clinical services on The facility's failure to notify the physician of 3/30/2012 at 10:30 am. significant behaviors for Resident #21 placed all residents on the 2nd Tennessee (2nd TN) unit in Resident #21 was transferred to an environment which was detrimental to their Medical Center for an Evaluation health, safety, and welfare. and placement to a behavior unit on 3/30/2012 at 4:00pm. The facility The findings included: 1 V i will not readmit this resident to the . 1 facility. Resident #21 was admitted to the facility on August 19, 2011, with diagnoses including Mental Disorder, Anxiety, and Previous Head Injury - The nurses' note for resident # 32 Traumatic. 7.21dated 1/14/2012 states the resident "having questionable bleeding from Medical record review of an assessment dated 1141 17 rectal area. MD notified with new February 12, 2012, revealed the resident scored 4 out of 15 on the Brief Interview for Mental orders to send resident to ER for Status (BIMS), indicating severe cognitive evaluation and treatment. RP was impairment, had exhibited physical behavioral notified of residents' status and aware of resident going to the ER." Nurse's symptoms directed toward others, and was note dated 1/14/2012 at 6:00pm states independent with ambulation. 4 4 the resident was admitted to BRMC with a diagnosis of Pneumonia. The Medical record review of the Mental/Behavioral hospital was not notified of the Health Progress Notes dated January 3, 2012, revealed, "...replied that he was concerned about possibility of a sexual assault. his ex-wife...went on to say that he has seen his wife w/ (with) other residents and this bothered · The Physician was notified of the him...went on to reiterate further delusional alleged sexual abuse allegation for beliefs about his ex-wife's behaviors...tends to resident #32 by the facility on 4/10/2012 by the Chief Executive obsess about this..." Office, Director of Nursing, Corporate

Medical record review of the Nurse's Notes dated

"...Resident also displaying some protectiveness i.e. (that is) female residents - resident raised his voice in loud tone this am (morning) when talking to male resident. This resident thought other male resident was (after) his wife...explained to

January 12, 2012, at 6:30 p.m., revealed,

Quality Assurance nurse and

Corporate Director of Clinical services.

FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 261 NORTH STREET **BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) N 669 Continued From page 32 N 669 this resident (reoriented) minimal success · The social worker completed a noted..." PHO9 assessment on 3/31/2012 to assess resident #32 for signs and Interview with Certified Nurse Aide (CNA) #1 on symptoms of depression and to identify March 30, 2012, at 1:52 p.m., in the conference possible changes in signs and room, confirmed resident #21 frequently symptoms of mood distress since her wandered the halls of the unit, in other resident last assessment. The assessment rooms, and liked to be with female residents in revealed that there was no change their rooms. Further interview confirmed the CNA from the residents' baseline. ((The had worked on two occasions in January 2012, PHQ-9 is a 9 item patient health when the resident was seen exiting a female questionnaire. A validated interview resident's room. Further interview confirmed the that screens for symptoms of first instance the CNA recalled was around the depression. It provides a standardized week of January 9, 2012, when the resident was severity score and a rating for evidence seen exiting a room (empty resident room which of a depressive disorder. The total 1130 had not been assigned to any residents) carrying severity provides a standard of linen. Interview confirmed the CNA entered the communication with clinicians and room and resident #32 was in bed with no clothes mental health specialist.) on, and a brief had been removed from the resident with blood present in the brief. Continued interview confirmed the CNA reported the incident to Licensed Practical Nurse (LPN) #11. Continued interview confirmed the CNA Resident #32 care plan was updated also observed the resident (resident #21) exiting by social services, MDS Coordinator resident #17's room sometime in January, and Ouality Assurance Nurse and Sr. upon entering the room, found the resident fully Director of clinical services on clothed, one side of the brief undone. 03/31/2012 to reflect the need to notify the MD and social services of changes Interview with LPN #11 on March 31, 2012, at in mood and behaviors. 7:15 a.m., and 9:00 a.m., on 2nd Tennessee, · The charge nurses will utilize the confirmed the LPN was working sometime in Psychoactive Medication monthly flow January when CNA #1 reported to LPN #11 record or the nurses notes to document resident #21 had exited a room (empty resident resident changes in mood and or room which had not been assigned to any behaviors. residents) carrying ladies clothing. Continued · It is the responsibility of the charge interview confirmed resident #32 was in the room. nurses to notify the MD and social with no clothes on, and a brief had been removed services of any mood and behavior (unknown who removed) with blood in the brief changes. and blood on the resident's rectal area

Continued interview confirmed LPN #11 was not

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by resident #21.

14. 2012 revealed no documentation the MD was

notified of possible sexual abuse to resident #32

Medical record review of the hospital records for

resident #32 dated January 14, 2012, revealed,

diaper...history of the dementia who is unable to provide a review of symptoms secondary to her

"...Chief complaint: Bright red blood in

The Director of Nursing; Assistant

Development Coordinator and or the Quality Assurance Nurse will provide

re-education to all licensed nurses

Director of Nursing; Staff

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behaviors..."

Medical record review of the nurse's notes dated January 19, 2012, at 6:15 p.m., revealed, "While walking down hallway on long hall 2nd TN (Tennessee) looking for (resident #21) noticed a

Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING TN8201 03/31/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **261 NORTH STREET** BRISTOL NURSING HOME BRISTOL, TN 37625 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 669 N 669 Continued From page 35 white sock in doorjam of rm (room). Upon entering room, (resident #21) was in bed A of room...along with female resident (resident #36). Female resident (resident #36) was fully clothed, • The Director of Nursing; Assistant not seeming to be disturbed by incident. Director of Nursing; Corporate (Resident #21) immediately started to rise out of Quality Assurance Nurse will provide bed at bottom of bed. His trousers were off, re-education to all licensed nurses on underwear on. He was told to put his pants on & implementing interim plans of care for exit room and was sent to dayroom. When new admissions, updating care plans female resident (resident #36) was asked about with resident changes including situation she said 'I don't know what this looks behavior changes. The training was like.' When asked if she was OK, harmed, or hurt initiated on 4/10/2012 and will be she stated she was 'OK'. Seemed to be unaware completed by 4/11/2012. of situation. Female resident was fully clothed in · All staff who missed the in-service gown, brief on & intact. Covers off resident. Call will be in-serviced by the staffing placed to Director of Nursing..." coordinator and or the corporate 1 Quality assurance nurse prior to being Interviews with the Senior Director of Clinical allowed to work the floor. Services on March 30, 2012, at 12:20 p.m., in the · The facilities do not use agency staff. conference room and with the DON on March 31, 2012, at 9:30 a.m., in the ADON's office, • The Unit Managers will audit the confirmed the facility had no incident reports or diabetic flow records daily to ensure investigations for the documented event January . . . Physician notification of hypoglycemic 19, 2012. /hyperglycemic episodes is documented on the Blood sugar flow sheets. Audits Medical record review of the Mental/Behavioral began 4/10/2012 Health Progress Notes for resident #21 dated January 19, 2012, revealed, "...alert and oriented to times 3...some confusion, less delusional beliefs...(Nursing staff requested this therapist visit w/ patient due to boundary issues: Pt (patient) entering other residents rooms at times, requiring some redirection)...asked Pt if he was aware of a problem involving a resident entering other residents' rooms causing some problems. Pt admitted that 'he had done this a couple of times by mistake and that he didn't mean to, adding a vague and superficial reason.' This Thx (therapist) provided Confrontive Therapy in

stating that Pt was oriented to location to his

PRINTED: 04/10/2012 FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING_ 03/31/2012 TN8201 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **261 NORTH STREET BRISTOL NURSING HOME** BRISTOL, TN 37625 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 669 N 669 Continued From page 36 room. Pt replied that he was. Pt replied that he would not enter other residents' rooms...reiterated boundary issues...clarifying loneliness in (is) no · The weekend Nurse Manager will excuse. Adequate understanding complete the daily audits on Saturday implementation remains questionable...often confused w/ some illogical thinking, poor and Sunday. judgment, some delusions..." · Daily audits will be completed Sunday through Saturday's for four Medical record review of the Psychiatric Note for weeks then, Three times a week resident #21 dated January 24, 2012, revealed, Sunday through Saturday for four 3.V 3 "...Staff report that resident continues his pursuit weeks and then, weekly Sunday 47 5 of female residents. They do not feel it is sexual through Saturday for four weeks and but more of wanting to lay beside them probably then PRN. because he misses his wife however there have been several close calls recently and staff have , ii. • The Unit managers will report audit noticed that he will take a piece of paper or a findings to the interdisciplinary team sock and put it in the door while he is inside with (Director of Nursing(DON), Assistant 31 1 a female resident..." Director of Nursing(ADON), Chief Executive Officer(CEO), Social Medical record review of the Mental/Behavioral Services (SS), Admissions, Business Health Progress Notes dated January 31, 2012, Office Manager(BOM), Rehab revealed, "...alert and oriented to times Director (RD)) in the daily clinical 3...Thoughts processes relevant, confused, some meeting. The DON/ADON will delusional beliefs...Re-emphaiszed w/ Pt the maintain all Audit tools in the survey importance of not entering anyone else's room. readiness binder in the DON's office. Pt agreed..." The DON/ ADON and or Quality Medical record review of the Social Service Assurance Nurse will audit 100% of Progress Notes for resident #21 revealed a note the diabetic flow sheets weekly to dated February 16, 2012, "Care Plan ensure Physician notification of Review...Behavior concerns discussed as related hyperglycemic episodes has been to how resident wants to help others - i.e. (that is) documented on the blood sugar flow transfers, etc. (etcetera) - will cont. (continue) to sheets. Audits will be completed weekly monitor..."

Medical record review of the Social Service Progress Notes dated March 9, 2012, revealed, "Attempted referral to 5-E (psychiatric unit) transported to hospital...aggressive behavior toward another individual..." Review of the Social for eight weeks and then PRN. Audits

began 4/10/2012.

FORM APPROVED Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING TN8201 03/31/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **261 NORTH STREET BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 669 N 669 Continued From page 37 · The DON and or ADON will review Service Progress Notes revealed no other Psychiatric consultation notes after documentation of the resident's behaviors or any each visit to ensure recommendations incidents with the resident exiting female resident for medication adjustments are called rooms. to the Physician in a timely manner. Medical record review of the Mental/Behavioral • The DON/ ADON and or Quality Health Progress Notes dated March 15, 2012, Assurance Nurse will audit 100% of revealed, "...alert and oriented to person and the Psychiatric notes and the medical situation...mildly anxious...(Nursing staff record to ensure the physician is requested this therapist visit w/ Patient due to notified of recommendations for some boundary issues and some behavioral medication changes from Psychiatric --1 + problems)...Since Pt denied having any problems. services. Confrontive Therapy necessary relative to Pt's intruding into other residents' rooms. Pt stated · Audits will be completed weekly for that he gets a little confused at times. This Thx eight weeks and then biweekly for countered w/ Pt's ability to find his own room...Pt eight weeks and then PRN. said he would remember to do this, he added that 1941 1 he is a nice man and does not want to cause The DON/ADON will report audit problems..." findings to the interdisciplinary team (Administrator, Director of Nursing, Observation of the resident on March 29, 2012, at Assistant Director of Nursing, Business 10:37 a.m., on the 2nd TN hallway revealed the resident was pushing resident #17 down the hallway in a wheelchair, a CNA stated "are you going to be nice to her," allowing the resident (resident #21) to continue to push the resident (resident #17). Office Manager, Dietary Manager, Continued observation revealed LPN #4 **Activities Director, Social Services** intervened by taking resident #21 to the dayroom, Director, Therapy Manager) in the sitting the resident in a chair and leaving the monthly Quality Assurance Committee resident there with no staff present. Continued meeting until system compliance is observation revealed the resident stated, "They achieved. aren't going to stop me. They are taking my rights away." Continued observation at 10:45 a.m., revealed resident #21 was again pushing resident #17 down the hall in a wheelchair when

LPN #4 stated "(resident's name) will you let her go..." and resident #21 was redirected away from

resident #17 who was taken to a room.

FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 261 NORTH STREET **BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 669 Continued From page 38 N 669 Interview with CNA #2 on March 30, 2012, at 9:05 a.m., at the 2nd TN nursing station, confirmed · To ensure the facility staff resident #21 had wandering behaviors, was very understand how to properly manage protective of female residents, liked to crawl into residents with behaviors, how to bed with female residents, had been "fondling report, investigate and implement women last few months...any woman - no one in interventions after a behavioral event. particular...I think he knows more than he lets on. All staff will receive education on: He knows what he is doing." Continued interview Managing residents with Dementia confirmed the resident had been found in bed. and Dementia related behaviors. AN A without clothes on, with one female resident. Contracted Hospice provider is Continued interview confirmed "He is like this -11 v 157 v

Interviews with LPN #6 and LPN #7 on March 30. 2012, at 9:25 a.m., and 10:00 a.m., at the 2nd TN nursing station, confirmed the resident had a history of aggressive behaviors, which had been worsening since the resident's ex-spouse died in November, 2011, and he associated other female residents with his wife/ex-wife. Continued interview confirmed the resident was difficult to redirect at times and interventions did not work. Further interview confirmed the staff were to fill out incident reports when residents had altercations.

every day with females."

Interviews with resident #38 and LPN #7 on March 30, 2012, at 9:40 a.m., at 2nd TN nursing station, revealed the LPN stated resident #38 was a reliable source of information and wanted to report an incident concerning resident #21. Interview with resident #38 revealed the resident was awakened early that morning with resident #21 standing over resident #38's bed, and resident #21 "scared" resident #38 causing resident #38 to slap resident #21's arm. Resident #38 stated resident #21 came to resident #38's room "more than I like" and resident #38 stated "I don't like it."

- scheduled to provide the above training. The training began on 4/5/2012 and will be completed by April 11, 2012.
- Implementation of interventions to prevent a behavior. Contracted Hospice provider is scheduled to provide the above training. The training began on 4/5/2012 and will be completed by April 11, 2012.
- Implementation of interventions after a behavioral event has occurred. Contracted Hospice provider is scheduled to provide the above training. The training began on 4/5/2012 and will be completed by April 11, 2012. The training also included a review of the facility policy on Behavior assessment and monitoring by the Assistant Director of Nursing.

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ex-spouse's death in November 2011. Continued interview with the Social Services Coordinator revealed, "...never thought the resident's behavior could be possibly abusive, "inappropriate, but not sexually motivated ...not abuse ...unclothed ...We worked on that one incident that I know of...was in bed with her I think or helped her to bed...I

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behaviors began with the resident wanting to be with female residents and kiss female residents. Further interview confirmed the NP was only familiar with the one incident in January when the resident was found in bed with a female resident with her fully clothed and resident #21 with his pants off and underwear on. Further interview confirmed the resident had exhibited other sexual behaviors such as when being found in the

Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 261 NORTH STREET **BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5)**PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) N 669 Continued From page 41 N 669 female resident's room, a sock had been placed : 1 in the door jam and the NP was not sure if the resident was capable of intentionally blocking the door or if the dementia was causing the resident to act. Interview confirmed the NP believed medication interventions were needed to decrease the sexual behaviors, but depo-provera takes three months or more to show symptom improvement and "you do have to worry about 114 1 other females." Telephone interview with the resident's physician on March 30, 2012, at 6:00 p.m., and 6:20 p.m., confirmed the resident had been "intermittently violent" but the physician was unaware of the resident's behaviors with other female residents and did not recall ever being notified the resident was seen coming out of female resident's rooms or in bed with female residents. Further interview confirmed no one had notified the physician of the resident exiting a room where resident #32 was unclothed and blood was present in a brief and rectal area. Telephone interview with LPN #5 on March 31, 2012, at 1:00 p.m., confirmed the LPN was the nurse who had called the physician and sent resident #32 to the hospital and the LPN had "no knowledge" of resident #21 being in the room prior to resident #32 being found nude, with blood in a brief. Interviews with the 2nd TN LPNs, the Social Services Director, the DON, and the Senior Director of Clinical Services during the survey from March 26, through March 31, 2012. confirmed the facility had not identified resident #21's as sexually motivated or possibly abusive and no investigations were completed and the facility's abuse protocol was not followed for

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elevated blood sugars.

Interview and medical record review with the Director of Nursing on March 29, 2012, at 2:15 p.m., in the bookkeeper office, confirmed the facility failed to notify the physician of the February 6, 2012, Psychiatric Consultation recommendation until February 13, 2012, (7 days later) and failed to notify the Physician of the

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Traumatic.

The findings included:

Resident #21 was admitted to the facility on August 19, 2011, with diagnoses including Mental Disorder, Anxiety, and Previous Head Injury -

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rooms, and liked to be with female residents in

had worked on two occasions in January 2012,

when the resident was seen exiting a female resident's room. Further interview confirmed the first instance the CNA recalled was around the week of January 9, 2012, when the resident was seen exiting a room (empty resident room which

their rooms. Further interview confirmed the CNA

responsibility of the charge nurses to

notify the MD and social services of

any mood and behavior changes.

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a.m., to 12:00 p.m. Continued interview

to completely undress herself. Continued

an opportunity for an inappropriate sexual

incident report had been completed or the

confirmed the LPN had never known resident #32

interview confirmed the LPN thought there was

situation to have occurred, but did not know if an

revealed that there was no change

(The PHQ-9 is a 9 item patient health

depression. It provides a standardized

questionnaire. A validated interview

from the residents' baseline.

that screens for symptoms of

Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 03/31/2012 TN8201 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **261 NORTH STREET BRISTOL NURSING HOME** BRISTOL, TN 37625 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N1207 N1207 Continued From page 46 severity score and a rating for evidence incident investigated. Continued interview of a depressive disorder. The total confirmed for incidents of sexual inappropriate severity provides a standard of behavior, staff were to immediately notify the communication with clinicians and supervisor in person or by phone, and the LPNs mental health specialist.) were not responsible for completing incident . 1 reports. Telephone interview with LPN #5 on March 31, • Resident # 32 care plan was updated 2012, at 1:00 p.m., confirmed the LPN was the by social services, MDS Coordinator nurse who had called the physician and sent 37 1 Quality Assurance Nurse and Sr. resident #32 to the hospital and the LPN had "no 2.1 Director of clinical services on knowledge" of the resident #21 was being in the 03/31/2012 to reflect the need to notify room prior to resident #32 being found nude, with the MD and social services of changes blood in a brief. in mood and behaviors. The Corporate Quality Assurance Nurse Medical record review of the nursing notes for and the Sr. Director of clinical services January 2012, for resident #32 revealed no EL 1 immediately notified the charge nurses documentation of an incident with resident #21 on duty of the changes made to the exiting the room. Review of the nursing notes for January 14, 2012, at 10:50 a.m., revealed, "Res care plan. · The Director of Nursing updated (resident) (resident #32) having questionable resident care guides to ensure the bleeding from rectal area. MD (physician) notified...Send res to ER (emergency room)..." nursing assistants were aware of the care plan changes on 4/11/2012. Medical record review of the hospital records for resident #32 dated January 14, 2012, revealed, "...Chief complaint: Bright red blood in diaper...history of the dementia who is unable to provide a review of symptoms secondary to her dementia...patient has had bright red blood noted in her diaper..." Interviews with the Senior Director of Clinical Services on March 30, 2012, at 12:20 p.m., in the conference room and with the Director of Nursing (DON) on March 31, 2012, at 9:30 a.m., in the Assistant Director of Nursing's (ADON's) office, confirmed the facility had no incident reports or investigations for the witnessed event January 14,

2012.

PRINTED: 04/10/2012 **FORM APPROVED** Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING TN8201 03/31/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **261 NORTH STREET BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PŘÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N1207 N1207 Continued From page 47 Medical record review of the Psychiatric Note for · The social worker completed a resident #21 dated January 17, 2012, revealed, PHQ9 assessment on resident # 36 on "...staff report that resident continues to have a 3/31/2012 to assess this resident for preoccupation with female residents. He has signs and symptom of depression and been found in a female resident's bed in the past. to identify possible changes in signs He is always pushing their with C's (wheelchairs) and symptoms of mood distress since or holding hands with various other residents. her last assessment. During the Staff are concerned this could escalate into a assessment this resident stated that this problem and wonder if depo-provera might be a 114 2 is not a good time for her, she is having possibility...he denies the above behaviors..." problems with her daughter and at . 1 times she has thoughts that she would 1.7 Medical record review of the nurse's notes dated be better off dead. The resident stated January 18, 2012, at 3:45 p.m., revealed, "...CNA no when the social worker asked her if came to this nurse and reported finding (resident she had a plan to harm herself. The 6.74 #21) in (room number) with him exiting the social worker notified the nurse. The doorway, female residents (resident #17) brief 101 nurse obtained an order for a undone & (and) her positioning vest off her body. Psychiatric evaluation. CNA directed male resident (resident #21) back • (The PHO-9 is a 9 item patient up hallway & redressed female resident (resident health questionnaire. A validated #17)..." 4:30 p.m., "Nurse practitioner psych interview that screens for symptoms of (psychiatric) ordered Depo Provera IM depression. It provides a standardized (intramuscular) once a month for sexual severity score and a rating for evidence behaviors..." of a depressive disorder. The total severity provides a standard of Interviews with the Senior Director of Clinical communication with clinicians and Services on March 30, 2012, at 12:20 p.m., in the completion mental health specialist.) conference room and with the DON on March 31, Date 2012, at 9:30 a.m., in the ADON's office, 4/11/12 confirmed the facility had no incident reports or

18, 2012.

investigations for the documented event January

Medical record review of the nurse's notes dated January 19, 2012, at 6:15 p.m., revealed, "While walking down hallway on long hall 2nd TN (Tennessee) looking for (resident #21) noticed a white sock in doorjam of rm (room). Upon entering room, (resident #21) was in bed A of room...along with female resident (resident #36).

· The nursing staff observed the

resident #36 through out the night and

FORM APPROVED Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING TN8201 03/31/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **261 NORTH STREET BRISTOL NURSING HOME** BRISTOL, TN 37625 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) N1207 N1207 Continued From page 48 Female resident was fully clothed, not seeming to be disturbed by incident. (Resident #21) completing thirty minutes observations immediately started to rise out of bed at bottom of until the resident was evaluated by bed. His trousers were off, underwear on. He psychiatric services. was told to put his pants on & exit room and was sent to dayroom. When female resident (resident A Psychiatric note dated 4/3/2012 #36) was asked about situation she said 'I don't reveals that this resident #36 know what this looks like.' When asked if she adamantly denies any thoughts, plans was OK, harmed, or hurt she stated she was or intent of self harm stating "I could 'OK'. Seemed to be unaware of situation. never do that, I have just been sadder 114 Female resident was fully clothed in gown, brief lately". on & intact. Covers off resident. Call placed to Director of Nursing..." · The M.D was notified and agreed to the recommendations for Medication Interviews with the Senior Director of Clinical changes and the discontinuation of the -1; Services on March 30, 2012, at 12:20 p.m., in the frequent checks by the unit manager conference room and with the DON on March 31. 34 1 on 2nd Tennessee. 2012, at 9:30 a.m., in the ADON's office, confirmed the facility had no incident reports or · A skin assessment was completed on investigations for the documented event January 135 1 resident # 36 on 3/18/2012, 3/30/2012 14 1 19, 2012. which revealed no bruising or redness. The skin assessment was completed by Medical record review of the Mental/Behavioral 11. 1 the charge nurse. Health Progress Notes for resident #21 dated January 19, 2012, revealed, "...alert and oriented • Resident # 36 care plan was updated to times 3...some confusion, less delusional with refer to psych services, monitor beliefs...(Nursing staff requested this therapist every 15 to 30 minutes until seen by visit w/ patient due to boundary issues: Pt Psych services. Social Worker, MDS (patient) entering other residents rooms at times, Coordinator, the Quality Assurance requiring some redirection)...asked Pt if he was Nurse and Sr. Director of clinical aware of a problem involving a resident entering services updated the care plan on other residents' rooms causing some problems. 03/31/2012. The Corporate Sr. Director Pt admitted that 'he had done this a couple of of Clinical Services and the Corporate times by mistake and that he didn't mean to. Quality Assurance nurse immediately adding a vague and superficial reason.' This Thx notified the nursing staff of the (therapist) provided Confrontive Therapy in changes in the care plan. stating that Pt was oriented to location to his

room. Pt replied that he was. Pt replied that he would not enter other residents' rooms...reiterated boundary issues...clarifying loneliness in (is) no

PRINTED: 04/10/2012 FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING TN8201 03/31/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **261 NORTH STREET BRISTOL NURSING HOME** BRISTOL, TN 37625 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N1207 N1207 Continued From page 49 · The M.D was notified and agreed excuse. Adequate understanding with recommendations from implementation remains questionable...often psychiatric services for Medication confused w/ some illogical thinking, poor changes and the discontinuation of the judgment, some delusions..." frequent checks on 4/3/2012. · Care plan was updated with D/C Medical record review of the Psychiatric Note for resident #21 dated January 24, 2012, revealed, frequent checks on 4/3/2012 by the unit manager. The Director of nursing "...Staff report that resident continues his pursuit updated the resident care guides to of female residents. They do not feel it is sexual but more of wanting to lay beside them probably ensure the nursing assistants were 14 1 because he misses his wife however there have aware of the changes to the plan of been several close calls recently and staff have care. noticed that he will take a piece of paper or a sock and put it in the door while he is inside with a female resident..." · The social worker completed a 45 PHQ9 assessment on resident #38 on Medical record review of the Mental/Behavioral 4/9/2012 to assess this resident for signs 14. Health Progress Notes for resident #21 dated and symptoms of depression and to January 31, 2012, revealed, "...alert and oriented to times 3... Thoughts processes relevant, identify possible changes in signs and confused, some delusional symptoms of mood distress since her beliefs...Re-emphaiszed w/ Pt the importance of last assessment. The assessment not entering anyone else's room. Pt agreed..." 411 1 revealed that there was no change from the residents' baseline. This Medical record review of the Social Service assessment was documented in the Progress Notes for resident #21 revealed a note social services note. dated February 16, 2012, "Care Plan (The PHQ-9 is a 9 item patient Review...Behavior concerns discussed as related health questionnaire. A validated to how resident wants to help others - i.e. (that is) interview that screens transfers, etc. (etcetera) - will cont. (continue) to for symptoms of depression. It monitor..." provides a standardized severity score and a rating for Medical record review of the Social Service

Progress Notes for resident #21 dated March 9,

2012, revealed, "Attempted referral to 5-E

individual..." Review of the Social Service Progress Notes revealed no other documentation of the resident's behaviors or any incidents with

hospital...aggressive behavior toward another

(psychiatric unit) - transported to

evidence of a depressive disorder.

communication with clinicians and

The total severity provides a standard

mental health specialist.)

of

FORM APPROVED Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING TN8201 03/31/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **261 NORTH STREET** BRISTOL NURSING HOME BRISTOL, TN 37625 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Continued From page 50 N1207 N1207 the resident exiting female resident rooms. · A skin assessment was completed on Medical record review of the Mental/Behavioral res. #38 on. 3/30/2012. The skin Health Progress Notes for resident #21 dated assessment revealed that the resident March 15, 2012, revealed, "...alert and oriented to 1 had bruising from blood draws and person and situation...mildly anxious...(Nursing around her Dialysis Shunt. The skin staff requested this therapist visit w/ Patient due assessment was completed by the to some boundary issues and some behavioral charge nurse. problems)...Since Pt denied having any problems. Confrontive Therapy necessary relative to Pt's LLY L Resident # 38 care plan was updated intruding into other residents' rooms. Pt stated .1 . by social services, MDS Coordinator that he gets a little confused at times. This Thx 117 **Quality Assurance Nurse and Sr.** countered w/ Pt's ability to find his own room...Pt Director of clinical services on said he would remember to do this, he added that 03/31/2012 to reflect the need to notify he is a nice man and does not want to cause 9 th 0 the MD and social services of changes problems..." in mood and behaviors. The Corporate 1967 3 Ouality Assurance Nurse and the Sr. Observation of the resident on March 29, 2012, at Director of clinical services 10:37 a.m., on the 2nd TN hallway revealed the 64 6 immediately notified the charge nurses resident was pushing resident #17 down the 43) 1 on duty of the changes made to the hallway in a wheelchair, a CNA stated "are you care plan. going to be nice to her," allowing the resident • The Director of Nursing updated (resident #21) to continue to push the resident 13: : resident care guides to ensure the (resident #17). Continued observation revealed nursing assistants were aware of the LPN #4 intervened by taking resident #21 to the care plan changes on 4/11/2012. dayroom, sitting the resident in a chair and · The charge nurses will utilize the leaving the resident there with no staff present. Psychoactive Medication monthly flow Continued observation revealed the resident record to document resident changes in stated, "They aren't going to stop me. They are taking my rights away." Continued observation at mood and or behaviors. It is the 10:45 a.m., revealed resident #21 was again responsibility of the charge nurses to pushing resident #17 down the hall in a notify the MD and social services of wheelchair when LPN #4 stated "(resident's any mood and behavior changes. The name) will you let her go ... " and resident #21 was charge nurse will immediately notify redirected away from resident #17 who was taken the MD and social services of residents

to a room.

Interview with CNA #2 on March 30, 2012, at 9:05 a.m., at the 2nd TN nursing station, confirmed resident #21 had wandering behaviors, was very

URYC11

exhibiting abusive behaviors.

Division	of Upolth Coro Eco	ilitios				1 Order	ALLINOVED
STATEMEN	n of Health Care Fac IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULT A. BUILDIN B. WING	ANAC	(X3) DATE S COMPLE	ETED
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N1207	Continued From pa	ge 51		N1207			
	bed with female reswomen last few moparticularI think he he knows what he confirmed the resid without clothes on, Continued interview every day with female linear last of the last of	e residents, liked to disidents, had been "foonthsany woman - re knows more than his doing." Continued ent had been found i with one female resident had been found i with one female resident." I #6 and LPN #7 on hand 10:00 a.m., at the firmed the resident he resident had been found in the resident was diffically as a sociated other informed the staff were when residents had been found in the resident was diffically as a sociated other firmed the staff were when residents had been formed the staff were when residents had been formation and want information and want information and want in the resident was diffically as a staff were when residents had been formation and want information and want information and want in the resident was a staff were when residents had been formation and want information and want information and want in the resident was a staff were when residents and LPN #7 9:40 a.m., at 2nd TN et LPN stated resident information and want information and want in the residents had been formation and want in the resident was a staff was a staf	ndling no one in ne lets on. interview n bed, dent. e this March 30, ne 2nd TN nad a ad been ne died in ner female ed ficult to ot work. re to fill 7 on I nursing nt #38 was		2. How will you identify other residents having the potential affected by the same alleged deficient practice and what corrective action will be taked. All residents on 2 nd Tennessee affected by the same alleged despractice. Skin assessment was completed 100% of the resident in 2 nd Ten by the charge nurse to assess founknown bruises and or abrasing. The PHQ9 assessment tool was to assess residents for signs an symptoms of depression and to possible changes in signs and symptoms of mood distress since his/her last assessment. (The PHQ-9 is a 9 item patient health questionnaire. A validate interview that screens for symptoms of depression	en? emay be ficient I on nessee r ons. as used d identify ee	
	report an incident of Interview with resid was awakened earl #21 standing over resident #21 "scare resident #38 to slap #38 stated resident	oncerning resident # ent #38 revealed the y that morning with resident #38's bed, and d" resident #38 causo resident #21's arm. #21 came to resider ike" and resident #38	21. resident esident nd ing Resident t #38's	ā	provides a standardized severity and a rating for evidence of a depressive dis The total severity provides a stat of Communication with clinic and mental health specialist.)	order. ndard	Allilya Cowbay, a
8	Medical record revi	ew of an assessmen	t for				

resident #38 dated February 19, 2012, revealed the resident scored 14 out of 15 on the BIMS,

Division	of Health Care Faci	lities				T ONW	AFFROVED
	OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
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N1207	Continued From paindicating no cognitive March 30, 2012, revevery 15 minute observations, " talking about wome about I think my wife Resident talking about Sale wife" Observation of residente ADON and Corp Nurse on March 30, 4:02 p.m., on 2nd Tresident had been of since 10:30 a.m., are one supervision, durother residents. Cointerview confirmed to the hospital at 4:00 treatment of behavior Interview with the Sale March 30, 2012, at a Records office, confiaware the resident (attraction to females was due to the resident ex-spouse while in the ex-spouse's death in Continued interview	ge 52 ive impairment. ew of the Nurse's Novealed the resident was ervations and the foundation of the foundation of the foundation of the foundation of the folial services of the fol	tes for as on llowing dent en talking s if it was w with ance and until lithe necks ne to for the and anator on ical or was orker felt er" to the re the ces	N1207		is lowing reased to 7A-2 staff taffing I five A shift ain the 2nd aced a g's list A'.s, ign on s. onus red f an ar hour sen	
	resident's behavior of "inappropriate, but nabuseunclothed" incident that I know or helped her to bed offdid not view his	d, "never thought the could be possibly abused sexually motivated We worked on that ofwas in bed with he liI believe one had be behaviors as sexual to been making commend.	usive, dnot ne ner I think pottoms	ı	 To ensure the facility staff understand how to properly mar residents with behaviors, how to report, investigate and implementations after a behavioral All staff will receive education or 	nt e vent.	Mulys Coubsyin

FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING TN8201 03/31/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **261 NORTH STREET BRISTOL NURSING HOME** BRISTOL, TN 37625 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N1207 N1207 Continued From page 53 but stated the resident never verbalized sexual Managing residents with Dementia comments or "talked dirty." Continued interview confirmed the resident had been placed on and Dementia related behaviors. Depo-provera, which is used to treat sexual Contracted Hospice provider is behaviors. Continued interview confirmed the scheduled to provide the above Social Services Coordinator was not responsible training. The training began on for investigating incidents of possible abuse or 4/5/2012 and will be completed by physical altercations; incident reports for any April 11, 2012. alleged abuse were given to the DON who • Implementation of interventions to completed all incident investigations. prevent a behavior. Contracted 13 Hospice provider is scheduled to 1 Telephone interview with the Psychiatric Nurse provide the above training. The Practitioner (NP) on March 30, 2012, at 4:45 training began on 4/5/2012 and will be p.m., confirmed the NP had been treating the completed by April 11, 2012. resident (resident #21) in conjunction with a • Implementation of interventions 1946 clinical psychologist since the resident's after a behavioral event has occurred. ex-spouse died in November 2011. Continued Contracted Hospice provider is 11.5 interview confirmed they were unsure if the scheduled to provide the above psychotherapy actually worked but the training. The training began on psychologist provided therapy for the resident and 4/5/2012 and will be completed by provided the NP with progress reports so the NP April 11, 2012. could manage medications. Continued interview The training also included a review confirmed the resident suffered a very 111 11 of the facility policy on Behavior accelerated decline in which the resident was monitoring by assessment and more confused, sexually aggressive, was going the Assistant Director of Nursing. into other resident rooms, and was aggressive towards males. Continued interview confirmed when the resident's ex-wife died, the sexual The Corporate Sr. Director of behaviors began with the resident wanting to be clinical Services, corporate with female residents and kiss female residents. Quality Assurance Nurse and or Further interview confirmed the NP was only Director of Nursing will educate familiar with the one incident in January when the all staff on the types of abuse, the resident was found in bed with a female resident policy and procedure for with her fully clothed and resident #21 with his reporting and investigating abuse, pants off and underwear on. Further interview Sexual behaviors and possible confirmed the resident had exhibited other sexual

behaviors such as when being found in the female resident's room, a sock had been placed in the door jam and the NP was not sure if the resident was capable of intentionally blocking the

PRINTED: 04/10/2012 FORM APPROVED Division of Health Care Facilities STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING_ TN8201 03/31/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 261 NORTH STREET **BRISTOL NURSING HOME** BRISTOL, TN 37625 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) N1207 Continued From page 54 N1207 door or if the dementia was causing the resident to act. Interview confirmed the NP believed medication interventions were needed to decrease the sexual behaviors, but depo-provera sexual abuse. The training began takes three months or more to show symptom on 4/4/2012 and will end on improvement and "you do have to worry about 4/11/2012. This training also other females." included mandatory reporting of Elder Abuse Act Telephone interview with resident #21's physician on March 30, 2012, at 6:20 p.m., confirmed the 1 2 resident had been "intermittently violent" and the · All staff who missed the in-service physician had on two other occasions sent the will be in-serviced by the staffing resident to the emergency room for evaluation coordinator and or the corporate and admission to a psychiatric unit, but the Quality assurance nurse prior to being resident was returned to the facility without being allowed to work the floor. The facilities .-() admitted. Further interview confirmed the do not use agency staff. physician had been trying to have the resident 147 1 admitted to a psychiatric unit due to the need for .The Director of Nursing, Assistant more intense monitoring and management of Director of Nursing and or the Chief 20 behaviors. Further interview confirmed the Executive Director (Administrator) physician was unaware of the resident's will investigate all allegations of abuse behaviors with other female residents and did not immediately and will report the recall ever being notified the resident was seen 14" 1 allegations and the findings of the coming out of female resident's rooms. Further investigation to the appropriate state interview confirmed staff needed "to keep an eye agencies. on him." · The interdisciplinary team will review all allegations of abuse in the Resident #17 was admitted to the facility on daily clinical meeting and in the October 28, 2011, with diagnoses including monthly Quality Assurance meeting. Dementia, Abnormality of Gait, Muscle Weakness, and Malnutrition. Medical record review of an assessment dated January 22, 2012, revealed the resident was unable to complete the BIMS, had short and long term memory problems, severely impaired

cognition, and was totally dependent on all staff

Medical record review of the nurse's notes and

for activities of daily living.

Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 03/31/2012 TN8201 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 261 NORTH STREET **BRISTOL NURSING HOME** BRISTOL, TN 37625 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N1207 Continued From page 55 N1207 Social Service Progress Notes revealed no documentation of the incident on January 18. 2012, when resident #21 was observed exiting the resident's room with the resident's vest undone and one edge of the resident's brief undone. Resident #36 was admitted to the facility on November 14, 2011, with diagnoses including Senile Delirium and Alzheimer's. Medical record review of an assessment dated January 30, 2012, revealed the resident scored 3 out of 15 on the BIMS, indicating severe cognitive impairment, and was totally dependent on all staff for activities of daily living. 41 1 Medical record review of the nurse's notes and the Social Service Progress Notes revealed no documentation of the incident on January 19, 2012, when resident #21 was found in resident #36's room, lying in the resident's bed with pants down, and underwear on. 711 1 Review of all incidents and investigations provided by the facility for resident #21 revealed the only incidents the facility had investigated were physical altercations with male residents dated February 4, February 5, February 7, March 1, March 9, and March 27, 2012. Review of the facility's policy Abuse/Neglect/Mistreatment: Guidelines for Prevention /Identification/Investigation, revealed, "...Sexual Abuse - sexual harassment, coercion or assault...The facility will be proactive in identifying occurrences, patterns and/or trends that may constitute possible/potential abuse or

neglect...The staff will be educated on the reporting procedure...and to report any concerns

Division	of Health Care Faci	lities	19			***************************************	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPI		(X1) PROVIDER/SUPPLIE				(X3) DATE SURVEY COMPLETED	
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			TH STREET , TN 37625				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE		
N1207	Continued From page 56		N1207				
	they may have with neglectshall track incidents/accidents occurrences that m abuse/neglectThe investigatetrends incidents/accidents neglect was involve investigation will be Executive Officer) of, or suspicion of ror neglect is to be to documented and rerequired to immedia (Director of Nursing duty, of anyobservesident abuse, neglective with the D3:25 p.m., in the D0 facility's abuse policiconfirmed all allegal	respect to abuse and and trend all and monitor for any any constitute potential facility willthorough noted during tracking, to determine if abusedThe results of the reported to the CEC. Any complaint of, obesident abuse, mistre thoroughly investigated portedAll employed ately notify the CEO of Services), or supervation of, or suspicional plect or mistreatment oon on March 29, 20 on soffice, and review and investigations and instances of	al hly g of se or e) (Chief oservation eatment ed, es are or DNS visor on n of"				
	Interviews with the Services on March conference room at 2012, at 9:30 a.m., confirmed the facilitinvestigations or int witnessed incidents #32, and #36 and ninvestigated as posinterviews confirme incidents. Interviews with the Services Director, t	serie to be reported, itness statements ob Senior Director of Cli 30, 2012, at 12:20 p. and with the DON on I in the ADON's office by had no incident representations related to regarding residents to incidents had been sible abuse. Further of they were unawared they were unawared and TN LPNs, the Senior Control of the Services during survey.	inical m., in the March 31, the #21, #17, e of the				

Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 03/31/2012 TN8201 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **261 NORTH STREET BRISTOL NURSING HOME** BRISTOL, TN 37625 (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N1207 Continued From page 57 N1207 March 26, through March 31, 2012, confirmed the facility had not identified resident #21's behaviors as sexually motivated or possibly abusive and no investigations were completed and the facility's abuse protocol was not followed. .y. i 3711 40 1 with . 1501. 7 24 1